Supreme Court, U.S.
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In the Supreme Court of the United States

UNITED STATES HEALTHCARE SYSTEMS
OF PENNSYLVANIA, INC.,

Petitioner,

v.

PENNSYLVANIA HOSPITAL INSURANCE CO. AND
THE COMMONWEALTH OF PENNSYLVANIA MEDICAL
PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND,

Respondents.

On Petition for a Writ of Certiorari to the Supreme Court of Pennsylvania

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PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether ERISA preempts a state tort action challenging a health maintenance organization's determination, under an ERISA-governed health plan, that a subscriber was eligible for coverage for services from a participating rather than a non-participating provider in the HMO's network.

RULE 14.1(b) AND 29.6 STATEMENT

Pursuant to Rule 14.1(b), petitioner United States Healthcare Systems of Pennsylvania, Inc., states that the other parties to this action are Pennsylvania Hospital Insurance Co. and the Commonwealth of Pennsylvania Medical Professional Liability Catastrophe Loss Fund. Basile Pappas and Theodora Pappas were plaintiffs in the trial court, but their claims against defendants Dr. David S. Asbel and Haverford Community Hospital were settled. App., *infra*, 46a n.2. As a result of the settlement, Mr. and Mrs. Pappas and Dr. Asbel are no longer parties to this litigation. After the settlement, respondents Pennsylvania Hospital Insurance Co. and the Commonwealth of Pennsylvania Medical Professional Liability Catastrophe Fund, who were the insurers for defendant Haverford Community Hospital, were substituted as the real parties in interest for the Hospital. *Ibid.*

Pursuant to Rule 29.6, petitioner states that the ultimate parent company of United States Healthcare Systems of Pennsylvania, Inc. ("U.S. Healthcare"), is Aetna Inc., a Pennsylvania corporation. U.S. Healthcare does business as the Health Maintenance Organization of Pennsylvania and Aetna U.S. Healthcare; it has no subsidiaries.

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Turner v. *Fallon Community Health Plan, Inc.*,
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K. Bartholomew, *ERISA Preemption of Medical Malpractice Claims in Managed Care: Asserting a New Statutory Interpretation*, 52 VAND. L. REV. 1131 (1999) 28

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R. Charrow & L. Greenlees, *ERISA Pre-emption — A Law in Search of a Doctrine*, HEALTH LAW DIGEST, March 1999, at 10 27-28

Amy Goldstein & Juliet Eilperin, *Bush Lobbies Hill On Patient Rights*, WASH. POST, July 27, 2001, at A1 27

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P. Jacobson & S. Pomfret, *Form, Function and Managed Care Torts: Achieving Fairness and Equity in ERISA Jurisprudence*, 35 HOUS. L. REV. 985 (1998) 28

K. Jordan, *Travelers Insurance: New Support for the Argument to Restrain ERISA Pre-emption*, 13 YALE J. ON REG. 255 (1996) 28

M. Morrissey, *An HMO Tale of Rashomon*, NAT'L L.J., June 18, 2001, at A1 30

Note, *What Is an Employee Benefit Plan? ERISA Preemption of "Any Willing Provider" Laws After* Pegram, 101 COLUM. L. REV. 1107 (2001) 16

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B. Richardson, *Health Care: ERISA Preemption and HMO Liability — A Fresh Look at ERISA Preemption in the Context of Subscriber Claims Against HMOs*, 49 OKLA. L. REV. 677 (1996) 27

A. Rosoff, *Breach of Fiduciary Duty Lawsuits Against MCOs: What's Left After Pegram v. Herdrich?*, 22 J. LEGAL. MED. 55 (2001) 29

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PETITION FOR A WRIT OF CERTIORARI

Petitioner respectfully asks this Court to issue a writ of certiorari to review the judgment of the Supreme Court of Pennsylvania in this case.

OPINIONS BELOW

The opinion of the Supreme Court of Pennsylvania on remand (App., *infra*, 1a-29a) is reported at 768 A.2d 1089. The prior opinion of the Supreme Court of Pennsylvania (App., *infra*, 30a-42a) is reported at 555 Pa. 342, 724 A.2d 889. The opinion of the Pennsylvania Superior Court reinstating the third-party complaint by defendant Haverford Community Hospital against petitioner (App., *infra*, 43a-55a) is reported at 450 Pa. Super. 162, 675 A.2d 711. The opinion of the Court of Common Pleas of Delaware County granting petitioner's motion for summary judgment on the third-party complaint (App., *infra*, 56a-65a) is unreported.

JURISDICTION

The Supreme Court of Pennsylvania rendered its decision on remand on April 3, 2001. App., *infra*, 1a. On June 18, 2001, Justice Souter extended the time within which to file a petition for a writ of certiorari to and including August 1, 2001. This Court's jurisdiction is invoked under 28 U.S.C. § 1257. See *Cox Broadcasting Corp.* v. *Cohn*, 420 U.S. 469, 482-483 (1975).[1]

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[1] On the prior occasion when this case came before this Court, in the exact same procedural posture as this occasion, respondent extensively challenged this Court's jurisdiction. Not only did petitioner demonstrate in its reply brief that this Court had jurisdiction, but also the Solicitor General, in his Court-invited amicus brief filed on December 17, 1999, expressly "agreed with petitioner * * * that this case meets the four requirements for immediate appellate review under *Cox*." 98-1836 U.S. Br. 7 n.4. The Court ultimately granted certiorari and vacated the judgment below. *United States Healthcare Sys. of Pennsylvania, Inc.* v. *Pennsylvania Hospital Ins. Co.*, 530 U.S. 1241 (2000). The Court's order was a standard "GVR" order and did not mention jurisdiction, but of course the Court could not have taken the

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The Supremacy Clause of the United States Constitution provides that the laws of the federal government "shall be the supreme Law of the Land; * * * any Thing in the Constitution or Laws of any State to the Contrary notwithstanding." U.S. CONST. Art. VI, cl.2.

Section 502(a) of ERISA states that "[a] civil action may be brought * * * (1) by a participant or beneficiary * * * (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan; * * * (3) by a participant, beneficiary, or fiduciary * * * (B) to obtain other appropriate equitable relief (I) to redress such violations [of this subchapter or the terms of the plan] or (ii) to enforce any provisions of this subchapter or the terms of the plan." 29 U.S.C. § 1132(a).

Section 514(a) of ERISA states that "the provisions of this title * * * shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a).

STATEMENT

A. Factual Background

Basile Pappas was a subscriber of the Health Maintenance Organization of Pennsylvania ("HMO Pa."), a subsidiary of petitioner, through an employee welfare benefit plan provided to his wife by her employer. App., *infra*, 57a-58a. HMO Pa. administers this benefit plan by contracting with participating providers to provide health care services to plan subscribers for

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action it did without satisfying itself of its own jurisdiction first. See *ASARCO, Inc.* v. *Kadish*, 490 U.S. 605, 621 n.1 (1989) (Court lacks "the power to disturb the state court's judgment," even summarily, when "we lack jurisdiction").

a pre-determined price. As a condition of coverage, subscribers agree to receive services from these participating providers, and pay a small co-payment and no deductible or co-insurance.

On May 20, 1991, Mr. Pappas went to his primary-care physician, Dr. David Asbel, complaining of neck and shoulder pain. App., *infra*, 57a. Dr. Asbel examined Mr. Pappas and treated him with an intramuscular injection of steroids. *Id.* at 44a. The next morning, Mr. Pappas was unable to walk and was experiencing numbness in his extremities. *Ibid.* He was transported by ambulance to Haverford Community Hospital. *Id.* at 57a. The emergency room physician at Haverford, Dr. Steven Dickter, diagnosed Mr. Pappas as suffering from an epidural abscess that pressed on his spinal column. *Id.* at 58a. Dr. Dickter concluded that Mr. Pappas should be treated at a "university" hospital, which would have more extensive facilities than Haverford. *Ibid.*

Dr. Dickter decided to transfer Mr. Pappas to Jefferson University Hospital. App., *infra*, 58a. When the ambulance arrived at Haverford at 12:40 p.m. to pick up Mr. Pappas, Dr. Dickter was informed by the ambulance personnel that Jefferson was not an HMO Pa. participating hospital, meaning that it was not one of the hospitals with which HMO Pa. contracts to provide hospital services to its plan members. *Ibid.* At 12:50 p.m., Dr. Dickter telephoned HMO Pa. to inquire as to Jefferson's status with HMO Pa. *Id.* at 44a.

The record reflects that Dr. Dickter spoke only with administrative — not medical — personnel of HMO Pa. Pa. Super. Ct. App. 67a-68a (deposition of Dr. Dickter at 47-52). The record further reflects that HMO Pa. administrative personnel consulted with their superior, the HMO's medical director, Dr. Leibowitz. *Ibid.* There is, however, no record of the considerations Medical Director Leibowitz took into account, or the information that was presented to him, in deciding whether to authorize treatment at Jefferson, because the parties opted not to depose Medical Director Leibowitz or to ask such questions of the administrative personnel who consulted with him.

Within fifteen minutes, HMO Pa. advised Dr. Dickter that coverage would not be provided for treatment at Jefferson, since it was not a participant in HMO Pa.'s network, but that there were three HMO Pa. participating university hospitals in the vicinity (Temple University, Hahnemann University, and Medical College of Pennsylvania) to which Mr. Pappas could be transferred. App., *infra*, 44a. No allegation has been made that these three hospitals were inferior to Jefferson, or that they were not appropriately equipped and staffed to treat Mr. Pappas' medical condition.

Thereafter, Dr. Dickter of Haverford called Dr. Asbel, Mr. Pappas's primary physician, to ascertain Dr. Asbel's preference concerning his patient's destination. App., *infra*, 58a. Dr. Asbel expressed a preference for Hahnemann, but Hahnemann delayed in responding to Dr. Dickter's request concerning its intensive care unit bed space availability. App., *infra*, 58a-59a. At approximately 2:20 p.m., Hahnemann called Dr. Dickter and advised him that it would be at least 30 more minutes before Hahnemann could determine whether it had space for Mr. Pappas. *Id.* at 59a Dr. Dickter then called Medical College of Pennsylvania, where Mr. Pappas was transported. *Ibid.*

Mr. Pappas and his wife brought a medical malpractice action against Dr. Asbel and Haverford, alleging that their delay in transferring Mr. Pappas to a hospital capable of treating his condition caused his spinal cord compression to continue and led to quadriplegia. App., *infra*, 6a n.2. Mr. and Mrs. Pappas did not sue petitioner. Haverford then filed a third-party complaint for contribution and indemnification against petitioner, complaining that it had "refused to authorize transfer of [Mr. Pappas] to a hospital selected by physicians at Haverford Community Hospital," namely Jefferson. Third-Party Cplt. ¶ 7. Haverford also incorporated the allegation in the Pappases' complaint that there was an inordinate delay in transferring Mr. Pappas from Haverford to a more suitable hospital. *Id.* ¶ 6.

B. Procedural History

1. After discovery, petitioner moved for summary judgment on the third-party complaint by Haverford on the ground that all of Haverford's claims are preempted by Section 514(a) of ERISA. The trial court granted the motion, stating that Haverford's allegations against petitioner "fall within the rubric of administration of an employee benefit plan. As such, the application of any state law in that regard implicates the ERISA preemption provision." App., *infra*, 62a. The trial court further observed: "Haverford Hospital seems to suggest that [petitioner] is responsible because its neglect led to a delayed delivery of health care benefits. Yet, there is no dispute but that the delay was occasioned while it was determined which facilities were available to the plaintiff under [petitioner's] programs. We cannot avoid the conclusion that this circumstance relates to the benefit plan." App., *infra*, 64a.

The plaintiffs' claims against Dr. Asbel and Haverford were settled. The trial court then entered an order substituting Haverford's insurers, respondents Pennsylvania Hospital Insurance Company ("PHICO") and the Commonwealth of Pennsylvania Medical Professional Liability Catastrophe Loss Fund (the "CAT Fund"), for Haverford as the real parties in interest to the claim for contribution or indemnification. App., *infra*, 46a n.2.

2. PHICO and the CAT Fund appealed the summary judgment order to the Pennsylvania Superior Court, which reversed. The Superior Court acknowledged that what was at issue was an administrative determination and that "the argument has *never* been advanced that the decision to withhold approval for transfer to Jefferson was *at all* related to medical considerations." App., *infra*, 50a (emphasis added). Nevertheless, the court held that Haverford's claims against petitioner were not preempted under Section 514(a) of ERISA. App., *infra*, 54a. According to the Superior Court, "[c]onsiderations of cost containment of the type which drive the decision making process in HMOs" are not encompassed within the preemptive ambit of Section 514(a). App., *infra*, 50a.

3. In its first consideration of this case ("*Pappas I*"), the Supreme Court of Pennsylvania, although disagreeing with the reasoning of the Superior Court, affirmed its decision that Haverford's claims against petitioner were not preempted. App., *infra*, 31a. The court acknowledged that this Court gave a "deliberately expansive" interpretation to the preemption provision in Section 514(a) of ERISA in *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. 41, 46 (1987); *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 96 (1983); and *Metropolitan Life Ins. Co.* v. *Massachusetts*, 471 U.S. 724, 739 (1985). App., *infra*, 35a. Expressly refusing to follow those decisions, however, the court asserted that they were overruled *sub silentio* by *New York State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Ins. Co.*, 514 U.S. 645 (1995); *California Div. of Labor Standards Enforcement* v. *Dillingham Construction*, 519 U.S. 316 (1997); and *DeBuono* v. *NYSA-ILA Medical & Clinical Services Fund*, 520 U.S. 806 (1997). App., *infra*, 35a-39a.

In a sweeping pronouncement not confined to the facts of this case, the Pennsylvania Supreme Court stated in *Pappas I* that, "[b]ased upon our interpretation of the *Travelers* line of cases, we conclude that negligence claims against a health maintenance organization do not 'relate to' an ERISA plan." App., *infra*, 39a. The court did not draw any distinction between negligence claims arising from an HMO's administration of plan benefits and negligence claims based on an HMO's purported vicarious liability for providers' malpractice or direct liability for its own exercise of medical judgment. Instead, the court's broad holding in *Pappas I* — which it reaffirmed in *Pappas II*, see App., *infra*, 2a, 14a — appears to preclude an HMO that has been sued for negligence from invoking the preemption provision of Section 514(a) under any set of circumstances.

4. On October 4, 1999, this Court invited the Solicitor General to file a brief expressing the views of the United States. 528 U.S. 804. The United States strongly disagreed with the broad holding of *Pappas I*, noting that *Travelers* reaffirmed, rather than questioned, the relevant holding of *Pilot Life*.

98-1836 U.S. Br. 16. The government also went further and considered whether a narrower rationale could be substituted for that indefensible broad holding. "When an HMO acts as a medical service provider, a number of courts have held — and we agree — that the HMO is subject to suit under state law for negligence in performing its medical duties." 98-1836 U.S. Br. 10. "On the other hand, when an HMO makes benefit determinations in its role as a plan administrator, most courts have held — and we agree — that ERISA preempts any state-law challenges to those decisions." *Ibid.* Despite a record that did not disclose any exercise of medical judgment and briefing that did not hint at any claim of such an exercise, the United States expressly considered, in the abstract, the possibility of the exercise of some medical judgment in the course of making a benefit eligibility determination. According to the government:

> As both the case law and the regulations show, such benefit determinations will often involve a significant component of medical judgment, and may have tragic medical consequences. But, so long as the judgment is an adjunct to a plan coverage decision, rather than a judgment made primarily in the course of diagnosis or treatment, it is a "benefit determination nonetheless."

Id. at 11 (quoting *Corcoran* v. *United Healthcare, Inc.*, 965 F.2d 1321, 1332 (5th Cir.), cert. denied, 506 U.S. 1033 (1992)).

The application of those abstract principles to the record in this case led to the unequivocal conclusion that "[r]espondents' common-law negligence claim is therefore preempted." 98-1836 U.S. Br. 14. As the government summarized (*id.* at 7):

> [I]t appears that petitioner denied Mr. Pappas a benefit he was entitled to receive under the terms of his plan — emergency care at a hospital outside the HMO network — and that respondents seek to hold petitioner liable for its negligence in making that erroneous benefit determination. When viewed in that light, respondents' claims are pre-empted by ERISA because they relate to plan adminis-

> tration and would provide an independent enforcement mechanism as an alternative to ERISA's limited remedies. As a result, the Pennsylvania Supreme Court decision is both incorrect in this case and overbroad as a general matter under existing law.

The United States rested its conclusions not only on the "relate to" language of Section 514(a), but also on the "field preemption" effect of ERISA Section 502(a), 29 U.S.C. § 1132(a), as construed in *Pilot Life*, 481 U.S. at 52. 98-1836 U.S. Br. 15-16.

The United States suggested that the Court hold the petition pending its decision in *Pegram* v. *Herdrich*, No. 98-1949, or, alternatively, grant plenary review because of "the conflict between the Pennsylvania Supreme Court and several courts of appeals, and the importance of the question presented here." 98-1836 U.S. Br. 6.

5. After this Court decided *Pegram* v. *Herdrich*, 530 U.S. 211 (2000), it granted the petition for certiorari in *Pappas I*, vacated the judgment, and remanded the case for further consideration. 530 U.S. 1241. Despite having called *Pappas I* both overbroad and wrong in its brief before this Court, the government filed a brief on remand before the Pennsylvania Supreme Court saying that its views "have changed in light of *Pegram*." U.S. Remand Br. 2. *Pegram*, according to the government, had "rejected the government's understanding * * * that an HMO's coverage decision is plan administration that is subject to ERISA's fiduciary standards even when it involves medical judgment about how to treat a patient." U.S. Remand Br. 11. In other words, the government was now taking the position — contrary to the position it took before this Court — that a coverage decision that included medical judgments was not necessarily "plan administration," but rather a "mixed treatment and eligibility" decision that would not be preempted. *Id.* at 12. Backing away from its earlier observation that there was *no* evidence in the record that petitioner made any medical decisions, the government now contended — without citing to the record — that petitioner's "transfer decision *may have*

involved some exercise of medical judgment." *Id.* at 16 (emphasis added). It therefore suggested that the Pennsylvania Supreme Court vacate the grant of summary judgment and remand to the Court of Common Pleas.

On remand ("*Pappas II*"), the Supreme Court of Pennsylvania, by a divided vote, held again that the claims against petitioner were not preempted. The majority rested its decision on two grounds. First, the majority "adhere[d] to [its] original opinion and order" and "confirm[ed] [its] original disposition." App., *infra*, 2a, 14a. Because, the majority held, its "analysis of ERISA preemption in *Pappas I* was founded on [Section 514(a) of ERISA] and the Supreme Court's most recent teaching on the matter," the analysis in *Pappas I* "continues to apply," App., *infra*, 14a n.7 — and thus "negligence claims against a health maintenance organization do not 'relate to' an ERISA plan," App., *infra*, 39a, and are therefore not preempted.

The majority also asserted that *Pegram* supports the same result. Although *Pegram* concerned fiduciary status under ERISA, and not the scope of ERISA preemption, the majority stated that *Pegram* set forth "two guiding principles." App., *infra*, 8a. First, "HMO physicians" act like both "plan administrators" and as "health care providers." Second, they may make "three types of decisions": "pure eligibility decisions," "treatment decisions," and "mixed eligibility and treatment decisions." Quoting *Pegram*, the majority stated (App., *infra*, 8a (citations omitted)):

> "[P]ure 'eligibility decisions' turn on the plan's coverage of a particular condition or medical procedure for its treatment," such as "whether a plan covers an undisputed case of appendicitis." "'Treatment decisions,' by contrast, are choices about how to go about diagnosing and treating a patient's condition: given a patient's constellation of symptoms, what is the appropriate medical response?" "Mixed eligibility and treatment decisions" are just what their name implies — decisions in which coverage and medical judgment are intertwined.

Under *Pegram*, the majority held, "an HMO's mixed eligibility and treatment decision implicates a state law claim for medical malpractice * * * [that] is not preempted by ERISA." App., *infra*, 11a. The majority ignored the contrary decision in *Corporate Health Ins., Inc.* v. *Texas Department of Ins.*, in which the Fifth Circuit held that "[w]e do not read *Pegram* to entail that every conceivable state law claim survives preemption so long as it is based on a mixed question of eligibility and treatment." 220 F.3d 641, 643 (5th Cir.), denying rehearing to 215 F.3d 526 (5th Cir. 2000), petition for cert. pending, No. 00-665. The majority also ignored the contrary decision in *Pryzbowski* v. *U.S. Healthcare, Inc.*, in which the Third Circuit held that ERISA § 502(a), 29 U.S.C. § 1132(a), did completely preempt a state-law claim that an HMO had negligently delayed approving a particular form of treatment — claims that like the ones in this case challenged "the policy adopted by [HMOs] requiring beneficiaries either to use in-network specialists or to obtain approval from the HMO for out-of-network specialists." 245 F.3d 266, 273 (3d Cir. 2001).[2]

The majority paid no heed, either, to the essential differences between the type of HMO involved in *Pegram*, in which the doctors who treated the patients were also owners/employees of the HMO, and HMO Pa., which contracts with independent doctors in private practice to provide all medical diagnosis and treatment. Finally, without citing the record — and contrary to what had been conceded throughout this litigation — the majority held that the "undisputed facts" established that petitioner's decision not to approve transfer to an out-of-network hospital was one of "mixed eligibility and treatment." App., *infra*, 12a-13a.[3] The claims therefore survived.

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[2] "Where a claim is preempted under § 502(a) it is necessarily preempted under § 514(a)." *Rice* v. *Panchal*, 65 F.3d 637, 646 n.10 (7th Cir. 1995). Respondents have previously conceded this point. 98-1836 Br. in Opp. 8.

[3] In so holding, the majority asserted that Medical Director Leibowitz, who made the decision not to approve benefits for a non-participating hospi-

Justice Saylor dissented. Citing both *Corporate Health Ins.* and *Pryzbowski*, he warned that "there remains a division of authority regarding the appropriate construct pursuant to which ERISA preemption of laws regulating the decisions of managed care organizations should be determined" — and, in particular, that "other courts have been more circumspect" in holding that state claims are not preempted. App., *infra*, 16a. Justice Saylor read *Pegram* to "give[] cause for the exercise of a degree of caution" on courts' parts in "defining the duties of managed care organizations (or at least those that are deemed to perform administrative functions under ERISA) for purposes of tort jurisprudence." App., *infra*, 17a. In particular, Justice Saylor wrote, contrary to the majority's reading *Pegram* manifested this Court's "disapproval of standards that would penalize HMOs based solely upon their structure and/or system for doing business." *Id.* at 20a. Justice Saylor then echoed the Third Circuit's comments in *Pryzbowski*: "A holding that Pryzbowski's claims against U.S. Healthcare" — claims indistinguishable in relevant part from the ones in this case — "are not completely preempted would open the door for legal challenges to core

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tal, was exercising "clinical judgment" (App., *infra*, 13a). Even if that statement had support in the record, it hardly would resolve the question whether the HMO's decision remained a "benefit determination" squarely governed by *Pilot Life*. Rather, as the United States correctly observed in 1999, a non-treating physician's determination with regard to benefit eligibility unquestionably constitutes an interpretation of the ERISA-governed plan, even if clinical judgment is involved. See 98-1836 U.S. Br. 11. But in any event the Pennsylvania court made up the "fact" of the exercise of "clinical judgment" out of thin air. Nothing in the record supports any suggestion that Medical Director Leibowitz was doing anything other than administering the plan and making a standard benefit eligibility determination. Indeed, the majority's newly minted suggestion in *Pappas II* that medical judgments were involved was contrary to the court's position in *Pappas I*, as the Solicitor General noted. 98-1836 U.S. Br. 12. Rather, "the undisputed facts indicate that petitioner, responding to an inquiry from a physician on behalf of a patient, made a *benefit determination*," *ibid.* (emphasis added), and not a medical decision. See also App., *infra*, 50a ("the argument has *never* been advanced that the decision to withhold approval for transfer to Jefferson was *at all* related to medical considerations") (emphasis added).

managed care practices (e.g., the policy of favoring in-network specialists over out-of-network specialists)." Those challenges, however, were precisely the ones "eschewed in *Pegram*." App., *infra*, 20a n.6 (quoting *Pryzbowski*, 245 F.3d at 274-275).

REASONS FOR GRANTING THE PETITION

A. The Decision Below Conflicts With This Court's Decisions Construing Sections 502(a) And 514(a) Of ERISA

The third-party complaint by Haverford against petitioner challenges a straightforward and commonplace ERISA plan benefit eligibility determination: coverage would be provided to Mr. Pappas if he was transferred to any of three hospitals that had contracted with petitioner to provide hospital services to plan members, but would not be provided if he was transferred to Jefferson, which had no such contractual relationship with petitioner. Because Haverford's negligence claim against petitioner arises from and directly relates to the administration of benefits under the ERISA-governed health plan, and provides an alternative enforcement mechanism to ERISA, it falls squarely within the preemptive scope of Sections 502(a) and 514(a) of ERISA.

As the United States recognized in its *amicus* brief in *Pappas I*, the Pennsylvania Supreme Court's decision directly conflicts with this Court's decision in *Pilot Life*.[4] In *Pilot Life*, plaintiff had alleged that an insurance company engaged in the processing and review of claims for benefits under an employee benefit plan had acted tortiously when it terminated his disability benefits. Relying on *Metropolitan Life* and *Shaw*, this Court emphasized the "expansive sweep of the pre-emption clause" in Section 514(a) of ERISA. *Pilot Life*, 481 U.S. at 47. The Court noted that the legislative history of ERISA reflects

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[4] 98-1836 U.S. Br. 6 ("the blanket non-preemption rule announced by the Pennsylvania Supreme Court conflicts with the core holding of *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. 41, 48 (1987)").

"both the breadth and importance of the pre-emption provisions." *Id.* at 46. The Court held that "[t]he common law causes of action raised in Dedeaux's complaint, each based on alleged improper processing of a claim for benefits under an employee benefit plan, undoubtedly meet the criteria for pre-emption under § 514(a)." *Id.* at 48. The Court further held that "varying state causes of action for claims within the scope of § 502(a) would pose an obstacle to the purposes and objectives of Congress." *Id.* at 52.

The Pennsylvania Supreme Court's decision also conflicts with this Court's decisions in *Metropolitan Life* and *Shaw*. In both of those cases, this Court held that ERISA preempts state laws that require an ERISA-governed plan to provide certain types of coverage, because such a requirement "bears indirectly but substantially on all insured benefit plans." *Metropolitan Life*, 471 U.S. at 739. The Pennsylvania Supreme Court's ruling subjects petitioner and other health maintenance organizations to tort liability for failing to authorize a member's treatment at a non-participating hospital. In essence, the decision imposes a substantive coverage requirement on ERISA-governed health plans: either permit a member to be admitted to whatever hospital the treating physician selects — regardless of whether that hospital participates in the health maintenance organization's network — or face liability in tort for damages. Such a result cannot be reconciled with *Metropolitan Life* and *Shaw*. Moreover, it would wreak havoc on the federal and state HMO laws requiring plans to establish networks of participating providers. See 42 U.S.C. § 300e; 28 Pa. Code § 9.75.

The Pennsylvania Supreme Court tacitly acknowledged in *Pappas I* that the third-party complaint against petitioner would be preempted under *Pilot Life*, *Shaw*, and *Metropolitan Life*, but it expressly declined to follow those decisions, characterizing them as "superannuated." App., *infra*, 37a. Instead, it took the view that this Court "noticeably changed tack" in *Travelers* by adopting a "new position on ERISA preemption," and it further opined that "*Travelers* and its progeny [*Dillingham* and

DeBuono] have thrown the expansive holdings of those earlier cases into question." App., *infra*, 35a, 37a, 38a. The Pennsylvania Supreme Court relied very heavily in *Pappas I* on the concurring opinion in *Dillingham* by Justice Scalia (joined by Justice Ginsburg), and it asserted that Justice Scalia had "reproached the Court for not forthrightly acknowledging that the holdings of these older cases 'have in effect been abandoned.'" App., *infra*, 37a. However, the Pennsylvania Supreme Court truncated its quotation of Justice Scalia's comment, deleting the earlier part of his sentence in which he noted that the Court's opinion in *Dillingham* "does obeisance to all our prior cases." 519 U.S. at 335. Justice Scalia also stated in his concurring opinion in *Dillingham* that the majority opinion "is a fair description of our prior case law, and a fair application of the more recent of that case law" (*ibid.*), thereby acknowledging that *Pilot Life* remained good law.

Similarly, contrary to the Pennsylvania Supreme Court's mistaken belief, this Court's decision in *Travelers* did not overrule *Pilot Life*, *Shaw*, or *Metropolitan Life*, either expressly or by implication. To the contrary, *Travelers* concludes by expressing "fidelity to the views expressed in our prior opinions on the matter." 514 U.S. at 668. The continuing vitality of *Pilot Life* and *Metropolitan Life* was most recently reaffirmed by this Court's decision *in UNUM Life Ins. Co. of Am.* v. *Ward*, 526 U.S. 358 (1999).

In addition to *Travelers*, the Pennsylvania Supreme Court relied in *Pappas I* on *DeBuono* v. *NYSA-ILA Medical & Clinical Serv. Fund*, 520 U.S. 806 (1997), in support of its contention that this Court's earlier decisions in *Pilot Life*, *Shaw*, and *Metropolitan Life* had been tacitly overruled. However, in *DeBuono*, this Court said just the opposite: it emphasized that these cases were not overruled, noting that "[i]n our earlier ERISA pre-emption cases, it had not been necessary to rely on the expansive character of ERISA's literal language in order to find pre-emption because the state laws at issue in those cases had a clear 'connection with or reference to' * * * ERISA

benefit plans." *Id.* at 813. Here, too, it is not necessary to rely on an expansive interpretation of "relate to" in order to find preemption, because the negligence claim at issue arises directly from the petitioner's administration of benefits under the plan. Allegations that petitioner should have pre-approved Mr. Pappas's admission at a non-participating hospital and that it delayed unduly in advising the treating physician as to the participating hospitals to which Mr. Pappas could be transferred have a clear and direct "connection with or reference to" Mr. Pappas's benefit plan, and thus are preempted.

Travelers involved a state law having only a peripheral connection to ERISA benefit plans; significantly, the Court contrasted the statute before it with earlier cases where "ERISA pre-empted state laws that mandated employee benefit structures or their administration." 514 U.S. at 658. Here, subjecting petitioner to potential liability in tort on account of its refusal to pre-authorize a subscriber's admission to a non-participating hospital is tantamount to "mandat[ing] employee benefit structures or their administration." This is certainly true when an administrator makes a pure eligibility decision, as petitioner did here, but it is no less true when an administrator makes a "mixed eligibility and treatment" decision: in both cases, tort liability "would have a marked effect on plan administration," *UNUM Life Ins.*, 526 U.S. at 378-379. Given that effect, such a state-law claim would clearly "relate to" an ERISA plan under Section 514(a) and would thus be preempted.

Nor was the Pennsylvania Supreme Court free to disregard *Pilot Life*, *Shaw*, and *Metropolitan Life* simply because it thought them "superannuated." App., *infra*, 37a. This Court has admonished lower courts not to anticipate the overruling of precedent, stating that "[o]ur decisions remain binding precedent until we see fit to reconsider them, regardless of whether subsequent cases have raised doubts about their continuing vitality." *Hohn* v. *United States*, 524 U.S. 236, 252-253 (1998); accord *Rodriguez de Quijas* v. *Shearson/American Express, Inc.*, 490 U.S. 477, 484 (1989) ("If a precedent of this Court has

direct application in a case, yet appears to rest on reasons rejected in some other line of decisions, the [lower court] should follow the case which directly controls, leaving to this Court the prerogative of overruling its own decisions.").

The Pennsylvania Supreme Court's unprecedented holding in *Pappas I* — expressly reaffirmed in *Pappas II* — that any and all negligence actions against health maintenance organizations do not "relate to" an ERISA plan stands in direct conflict with this Court's decision in *Pilot Life*, where this Court held that Sections 502(a) and 514(a) preempt suits alleging improper processing of a claim for benefits. A cause of action predicated on a health maintenance organization's alleged negligence in administering benefits under an ERISA-governed plan plainly "relates to" the plan and provides an alternative enforcement mechanism not contemplated by ERISA itself, and is therefore preempted under Sections 502(a) and 514(a) of ERISA.

This Court's recent decision in *Pegram* does not suggest otherwise. To begin with, *Pegram* was not a preemption case at all, holding only that ERISA does not impose a fiduciary duty on HMO physicians for their mixed eligibility and treatment decisions. 530 U.S. at 237. Indeed, the Court nowhere even alluded to the meaning of the critical phrase "relate to" in Section 514(a) or to the scope of field preemption effected by Section 502(a). The Court did, however, specifically note that it did not have occasion "to discuss the interaction" of claims for denials of benefits "with state law causes of action." 530 U.S. at 229 n.9; see also Note, *What Is an Employee Benefit Plan? ERISA Preemption of "Any Willing Provider" Laws After* Pegram, 101 COLUM. L. REV. 1107, 1123 (2001) ("Of course, even after *Pegram*, the previous cases analyzing the meaning of 'relate to' remain good law.").

Moreover, in *Pegram* this Court eschewed legal challenges to practices like the "rationing" of care that "go[] to the very point of any HMO scheme." 530 U.S. at 221; see also *Pryzbowski*, 245 F.3d at 274-275. Subjecting petitioner to state tort law

liability for providing coverage at network hospitals rather than an out-of-network hospital would thus be contrary to — not consistent with — *Pegram*.

In fact, in his dissent in this case Justice Saylor noted that even on the majority's terms petitioner's decision would have survived, given the important difference between the types of HMOs involved here and in *Pegram* (App., *infra*, 17a n.3):

> [T]he decision made in *Pappas* was far closer on the continuum to the eligibility form than that which was at issue in *Pegram*, since, under U.S. Healthcare's modified IPA-style structure, the decision was not made by the actual treating physician as was the case under the capitated arrangement at issue in *Pegram*. Indeed, arguably an IPA-style HMO's decision whether to pay for out-of-network services touches the eligibility end of the spectrum, since in relation to out-of-network providers, the HMO no longer itself functions as a service provider through its pre-arranged contracts, but rather, is relegated to a traditional fee-for-service insurance function. *See generally Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266, 2001 WL 292997, 2001 U.S. App. LEXIS 4903 (3d Cir. Mar. 27, 2001) (holding that a delay-in-approval claim against U.S. Healthcare fell squarely within the realm of the HMO's administrative function).

Indeed, this type of litigation is so clearly preempted by the exclusive remedies set forth in ERISA that many courts of appeals would permit removal of a suit of this nature on that ground alone. Perhaps for that reason, Mr. and Mrs. Pappas never brought suit against petitioner. It would be anomalous to permit third parties, such as respondent, effectively to circumvent the congressional scheme by the simple expedient of bringing a third-party complaint against petitioner.

B. The Decision Below Conflicts With Decisions By The Third Circuit And Numerous Other Courts Of Appeals Throughout The Country

Conspicuous by its absence from the decisions in *Pappas I* and *Pappas II* is the citation of any case from any court that supports either the Pennsylvania Supreme Court's astonishing assertion that all negligence claims against health maintenance organizations fall outside the preemptive scope of Section 514(a) or its alternative holding that all "mixed" decisions survive ERISA preemption in the wake of *Pegram*. Indeed, the Pennsylvania Supreme Court did not and could not cite any case in support, and none exists.

The Pennsylvania Supreme Court's affirmation in *Pappas II* of its ruling in *Pappas I* that all negligence claims against HMOs are not preempted conflicts with the Third Circuit's decisions in *Dukes* v. *U.S. Healthcare, Inc.*, 57 F.3d 350, cert. denied, 516 U.S.1009 (1995), and *Pryzbowski* v. *U.S. Healthcare, Inc.*, 245 F.3d 266 (2001), creating a split between the state and federal courts in Pennsylvania on this issue. Resolution of this conflict is necessary to prevent forum shopping. See *Yee* v. *City of Escondido*, 503 U.S. 519, 538 (1992) (granting certiorari to resolve conflict between Ninth Circuit and California state courts, this Court noted that "[f]orum shopping is thus of particular concern"); *Baldwin* v. *Alabama*, 472 U.S. 372, 374 (1985) (granting certiorari to resolve conflict between Eleventh Circuit and Supreme Court of Alabama).

In *Dukes*, the Third Circuit held that ERISA preempts claims based on utilization review decisions and other plan benefit eligibility determinations, but does not preempt claims challenging the quality of care a subscriber receives. The Pennsylvania Supreme Court's declaration that all negligence claims against a health maintenance organization are outside the preemptive scope of Section 514(a), even if they relate to the administration of benefits under a plan, is in direct conflict with *Dukes*. See *Huss* v. *Green Spring Health Services, Inc.*, No. 98-6055, 1999 U.S. Dist. LEXIS 5101, *13 (E.D. Pa. April 16,

1999) (noting the "tension" between *Dukes* and the Pennsylvania Supreme Court's decision in this case and following *Dukes*). Remarkably, the Pennsylvania Supreme Court made no mention at all of *Dukes* in either *Pappas I* or *Pappas II*, simply ignoring the suggestion by Justice Nigro in his concurring opinion in *Pappas I* to adopt the rationale of the *Dukes* decision. App., *infra*, 41a-42a.[5]

The *Pappas II* majority likewise ignored *Pryzbowski* (in the face of Justice Saylor's discussion of *Pryzbowski* in his dissent). In that case, construing Section 502(a), the Third Circuit held that ERISA completely preempted negligence and other state law claims arising from delay in approving requested services because such delay was "conduct falling squarely within administrative function." 245 F.3d at 274. As Judge Sloviter's opinion for the unanimous court explained: "A holding that Pryzbowski's claims against U.S. Healthcare are not completely preempted would open the door for legal challenges to core managed care practices (e.g., the policy of favoring in-network specialists over out-of-network specialists), which the Supreme Court eschewed in *Pegram*." *Id.* at 274-275. By comparison, in *Pappas II*, the Pennsylvania Supreme Court held that claims based on delay in approving treatment are not preempted by ERISA and characterized its own ruling in *Pappas I* as "consistent with the Supreme Court's decision in *Pegram*." App., *infra*, 13a-14a. As Justice Saylor observed in his dissenting opinion in *Pappas II*, there is a direct conflict between *Pappas II* and *Pryzbowski*. App., *infra*, 18a n.3.

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[5] In our prior certiorari petition (98-1836 Pet. 14 n.4), we explained that Justice Nigro misread *Dukes*. Furthermore, *Dukes* itself draws a tenuous and manipulable line between "quality of care" and "quantity of care" that may not ultimately represent a faithful interpretation of ERISA. But what matters for present purposes is that the Supreme Court of Pennsylvania has consistently ignored *Dukes* and drawn a line completely inconsistent with the analysis in *Dukes*, as well as inconsistent with the contrary post-*Pegram* decision on indistinguishable facts in *Pryzbowski*.

The Pennsylvania Supreme Court did acknowledge in *Pappas I* (though not in *Pappas II*) that a number of federal appellate decisions hold to be preempted or completely preempted negligence claims against health maintenance organizations that, like the claim asserted here against petitioner, arise from the administration and processing of claims for benefits under an ERISA-governed plan. App., *infra*, 38a n.5. However, just as it refused to follow this Court's pre-*Travelers* decisions because it believed they were no longer good law, so too did it disregard the many relevant court of appeals decisions, declaring that "it would be inappropriate for us to utilize the reasoning of these courts of appeal cases as they fail to discuss the *Travelers* line of decisions." *Ibid.*

In fact, after *Travelers*, the federal courts of appeals have continued to hold — uniformly — that, under *Pilot Life*, Sections 502(a) and 514(a) preempt claims arising from the administration of benefits under an ERISA plan, such as refusals to authorize coverage for a particular type of treatment or refusals to authorize coverage at a particular hospital. See *Pryzbowski*, 245 F.3d at 274 (claims for delay in approving surgery are preempted by ERISA because they involve "conduct falling squarely within administrative function"); *Thompson* v. *Gencare Health Sys., Inc.*, 202 F.3d 1072 (8th Cir. 2000) (ERISA preempted claims arising from refusal to authorize high dose chemotherapy or bone marrow transplant); *Hull* v. *Fallon*, 188 F.3d 939, 943 (8th Cir. 1999) (claims involving denial of thallium stress test "relate to the administration of benefits" and are preempted by ERISA), cert. denied, 528 U.S. 1189 (2000); *Danca* v. *Private Health Care Sys., Inc.*, 185 F.3d 1 (1st Cir. 1999) (ERISA preempted claims for denial of precertification for treatment at one hospital and precertification for admission to a different hospital); *Bast* v. *Prudential Ins. Co. of Am.*, 150 F.3d 1003, 1008 (9th Cir. 1998) (claims arising from delay in authorizing bone marrow transplant were preempted); *Parrino* v. *FHP, Inc.*, 146 F.3d 699, 705 (9th Cir.) (claims arising out of delay in approving proton beam cancer therapy were preempted), cert. denied, 525 U.S. 1001 (1998); *Englehardt* v.

Paul Revere Life Ins. Co., 139 F.3d 1346, 1353 (11th Cir. 1998) (ERISA preempted tort challenge to plan's decision to deny plaintiff's claim for benefits); *Turner* v. *Fallon Community Health Plan, Inc.*, 127 F.3d 196, 199 (1st Cir. 1997) (ERISA preempted claims arising from refusal to authorize coverage for bone marrow transplant), cert. denied, 523 U.S. 1072 (1998); *Painter* v. *Golden Rule Ins. Co.*, 121 F.3d 436, 440 (8th Cir. 1997) (ERISA preempted claim stemming from refusal to authorize coverage for high-dose chemotherapy cancer treatment), cert. denied, 523 U.S. 1074 (1998); *Jass* v. *Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1495 (7th Cir. 1996) (ERISA preemption applies to "allegations of negligence based on a failure to treat where the plan denied benefits for the proposed treatment"); *Cannon* v. *Group Health Serv.*, 77 F.3d 1270, 1273 (10th Cir.) (ERISA preempted suit arising from delay in authorizing bone marrow transplant), cert. denied, 519 U.S. 816 (1996).[6]

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[6] The Pennsylvania Supreme Court's decision also conflicts with a number of pre-*Travelers* court of appeals decisions that, relying on *Pilot Life*, had held that ERISA preempted claims based on the alleged improper administration of benefits under a plan. *Tolton* v. *American Biodyne, Inc.*, 48 F.3d 937, 942 (6th Cir. 1995) (ERISA preempted claims arising from refusal to authorize psychiatric treatment under the plan; "American Biodyne and its employees were determining what benefits were available to Tolton under the plan."); *Spain* v. *Aetna Life Ins. Co.*, 11 F.3d 129, 131 (9th Cir. 1993) (ERISA preempted claim based on delay in authorizing coverage for bone marrow transplant; plaintiff's claim "seeks damages for the negligent administration of benefit claims"), cert. denied, 511 U.S. 1052 (1994); *Kuhl* v. *Lincoln National Health Plan*, 999 F.2d 298, 303 (8th Cir. 1993) (plan refused to certify payment for heart surgery at a hospital outside the plan's service area; "the decision not to precertify payment relates directly to Lincoln National's administration of benefits"), cert. denied, 510 U.S. 1045 (1994); *Corcoran* v. *United Healthcare, Inc.*, 965 F.2d 1321, 1332 (5th Cir.) (plan authorized home nursing care for pregnant woman rather than hospitalization; "the Corcorans are attempting to recover for a tort allegedly committed in the course of handling a benefit determination"), cert. denied, 506 U.S. 1033 (1992); *Settles* v. *Golden Rule Ins. Co.*, 927 F.2d 505, 509 (10th Cir. 1991) (claim based on allegedly unlawful termination of coverage was preempted; "[t]he factual basis for each of plaintiff's state law claims directly concerns the alleged improper administration of the benefit plan").

Not only is there a direct conflict between the broad holding that *no* "negligence claims against a health maintenance organization" can "'relate to' an ERISA plan" under Section 514(a) and the federal courts of appeals cases cited above, there is an equally direct conflict between the federal courts of appeals and the alternative holding in *Pappas II* that "mixed eligibility and treatment" decisions can, in light of *Pegram*, be challenged under state law. In *Corporate Health Ins.* — which the Pennsylvania Supreme Court failed to mention — the Fifth Circuit stated so expressly: "[W]e do not read *Pegram* to entail that every conceivable state law claim survives preemption as long as it is based on a mixed question of eligibility and treatment." 220 F.3d at 643. Here, the Pennsylvania Supreme Court read *Pegram* exactly as the Fifth Circuit did not. And the Pennsylvania Supreme Court's decision conflicts as well with the Third Circuit's decision in *Pryzbowski*.

There, a patient sued under state law for supposed negligence in an HMO's delay in authorizing particular treatment. Borrowing the same terminology from *Pegram* as did the Pennsylvania Supreme Court, the Third Circuit held that such a claim was one "to enforce [a person's] rights under the terms of the plan" and thus completely preempted under ERISA Section 502(a) and, *a fortiori*, "relate[d] to" a plan under Section 514(a). See 245 F.3d at 274-275 (preemption of delay claims consistent with *Pegram*'s rejection of "legal challenges to core managed care practices (e.g., the policy of favoring in-network specialists over out-of-network specialists)").[7]

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[7] See also *Calad* v. *Cigna Healthcare of Texas, Inc.*, No. CIV. 300-CV-2693-H, 2001 WL 705776 (N.D. Tex. June 21, 2001) (noting that *Pegram* "was not a preemption case" and holding that "claims arising from a delay or denial of benefits are ERISA-preempted"); *Roark* v. *Humana, Inc.*, No. CIV. A. 3:00-CV-2368D, 2001 WL 585874, *4 (N.D.Tex. May 25, 2001) (holding *Pegram* inapplicable to claim for delay or denial of approval for skilled nursing home care because the claim "is about administration of benefits, not quality of medical treatment"); *Rubin-Schneiderman* v. *Merit Behavioral Care Corp.*, 25 EMPL. BEN. CAS. 2542 (CCH) ¶ 23971U (S.D.N.Y. Apr. 10, 2001) (relying on *Pryzbowski* for holding that

Critical to the Third Circuit's analysis under *Pegram* was its understanding that this Court determined that Congress wanted to *reject* broad-based state-law attacks on the business justifications for HMOs. A claim such as the one in *Pryzbowski* — and the one here — that an HMO had wrongly delayed or denied benefits "would open the door for legal challenges to core managed care practices (e.g., the policy of favoring in-network specialists over out-of-network specialists)." 245 F.3d at 274-275. Such challenges are precisely the kind that Congress decided to preempt. See *id.* at 275 (noting that in *Pegram* the Court "reject[ed] claims attacking financial incentives behind HMO structure, in light of [the] congressional policy of promoting HMOs").

Petitioner's decision that Mr. Pappas would be afforded coverage if he was transferred to any of the three designated participating hospitals, but not if he was transferred to a non-participating hospital (Jefferson), was a prototypical determination concerning the eligibility of Mr. Pappas to benefits and under *Pilot Life* should have been held preempted. And even if petitioner's decision had been "mixed" (which it was not), involving both an eligibility determination and questions of treatment, it should also have been preempted. In holding that either *no* negligence claims are preempted, or that at least negligence claims challenging mixed decisions are not preempted, the Pennsylvania Supreme Court has created a conflict with decisions of other courts. The latter holding not only reflects an erroneous attribution of talismanic significance, for preemption purposes, to the "mixed" label, but also reflects a legally (see

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"determinations of whether requested treatment is covered under a policy relate to plan administration" and challenges to them are therefore preempted); *Schusteric* v. *United Healthcare Ins. Co. of Ill.*, No. 00 C 4156, 2001 WL 1263581, *2 (N.D. Ill. Sept. 5, 2000) ("*Pegram*'s discussion of whether the plaintiff could state a claim for breach of fiduciary duty under ERISA § 1109 says nothing about whether a negligence claim of the type alleged in this case [*i.e.*, for delay in approving physical therapy] is completely preempted by § 502(a).")

98-1936 U.S. Br. 11) and factually (see note 3, *supra*) erroneous classification of this case as one involving a "mixed" determination.

The third-party complaint brought by Haverford not only complains of petitioner's refusal to pre-authorize coverage for Mr. Pappas at Jefferson, but also alleges that petitioner contributed to the delay in transferring Mr. Pappas from Haverford to a more suitable hospital. App., *infra*, 6a & n.2. The Pennsylvania Supreme Court stated in *Pappas I* that "[c]laims that an HMO was negligent when it provided contractually-guaranteed medical benefits in such a dilatory fashion that the patient was injured indisputably are intertwined with the provision of safe medical care" and are not preempted. App., *infra*, 39a. However, that ruling conflicts with six of the federal appellate decisions cited above, where the courts of appeals held that, under *Pilot Life*, ERISA preempts claims based on undue delays by plan administrators in approving particular treatments or benefits. *Pryzbowski*, 245 F.3d at 273 ("Underlying these allegations of delay is the policy adopted by U.S. Healthcare (and many other HMOs) requiring beneficiaries either to use in-network specialists or to obtain approval from the HMO for out-of-network specialists. These activities fall within the realm of the administration of benefits."); *Bast* v. *Prudential Ins. Co.*, 150 F.3d 1003; *Parrino* v. *FHP, Inc.*, 146 F.3d 699; *Cannon* v. *Group Health Service*, 77 F.3d 1270; *Spain* v. *Aetna Life Ins.*, 11 F.3d 129; *Kuhl* v. *Lincoln Nat. Health Plan*, 999 F.2d 298.

The decision in *Pappas I*, as re-affirmed and expounded on in *Pappas II*, stands alone in its wholesale evisceration of the preemption defense that other courts have upheld for ERISA plan benefit eligibility determinations. As the United States observed in its amicus curiae brief in *Pappas I*, the Pennsylvania Supreme Court's decision "conflicts with a long line of federal court of appeals decisions, both before and after *Travelers*, holding that ERISA preempts state-law challenges to decisions by HMOs, insurers, utilization review organizations, and

other plan administrators to deny or delay authorization for particular medical treatments or treatment at particular hospitals." 98-1836 U.S. Br. 17. The conflict between the Pennsylvania Supreme Court's decision and all of the federal courts of appeals decisions referred to above is stark, and that conflict can be resolved only by this Court.

C. This Court's Review Is Needed To Bring Coherence To An Important Area Of Law That Has Caused Confusion In Lower Courts

Although this Court has rendered decisions in 18 cases addressing the boundaries of ERISA's preemptive reach,[8] it has not yet addressed ERISA preemption in the context of a medical malpractice or negligence-based action against an ERISA-governed health maintenance organization. This Court observed in *DeBuono* that the ERISA preemption issue has "generated an avalanche of litigation in the lower courts" (520 U.S. at 808 n.1); a significant portion of that avalanche is composed of malpractice and negligence lawsuits against health maintenance organizations.

Lacking guidance from this Court, the federal and state courts have struggled mightily with the interplay of Sections 502(a) and 514(a) of ERISA with the myriad types of tort claims asserted against health maintenance organizations and other ERISA-governed health plans. The courts have employed differing analytical frameworks, have reached widely divergent conclusions, and have created tremendous confusion, uncertainty, and unpredictability in a vitally important area of the law that affects the tens of millions of people who

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[8] The Court itself identified 16 cases in *DeBuono*, 520 U.S. at 808 n.1. Since then, the Court has decided *UNUM Life Ins.*, 526 U.S. 358, and *Egelhoff* v. *Egelhoff ex rel. Breiner*, 121 S. Ct. 1322 (2001). Contrary to the Pennsylvania Supreme Court's apparent belief that this Court no longer regards ERISA as having any meaningful preemptive scope, *Egelhoff* (in full) and *UNUM* (in part, 526 U.S. at 377-379) resulted in determinations that state law was preempted by ERISA.

participate in managed health care. Ascertaining the appropriate scope of ERISA preemption is crucial because ERISA affects virtually all Americans who obtain health benefits through a private employer. All health benefit plans obtained through a qualified employer are within the scope of ERISA, regardless of whether the benefits are provided through a contract with an insurer, an HMO, or a self-funded plan.

In its amicus curiae brief in *Pappas I*, the government stated (98-1836 U.S. Br. 18):

> We agree with petitioner (Pet. 19-22) that, regardless of the merits, this is an area of law of great importance. A majority of the 123 million Americans who receive health care through ERISA-regulated employee benefit plans are now subject to a managed care regime in which at least some coverage decisions are made before treatment is provided. * * * The profusion of litigation in the lower courts as to the extent of ERISA preemption with respect to activities by HMOs is further testament to the importance of the issues presented and the regularity with which they arise. And while Congress may eventually enact new legislation in this field, it has not yet done so, and the issues under current law are significant enough to warrant review by the Court.[9]

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[9] The government's December 1999 statement in this case that the issues are sufficiently important to deserve review in this Court notwithstanding the possibility of new legislation contrasts with its June 2001 statement that somewhat related issues — involving not preemption of state tort actions, but rather preemption of state statutes mandating external independent review of managed care organizations' medical necessity decisions — should not be reviewed because essentially the same issues are pending before Congress. Brief for the United States as Amicus Curiae (June 2001), *Montemayor* v. *Corporate Health Ins., Inc.*, No. 00-665, and *Rush Prudential HMO, Inc.* v. *Moran*, No. 00-1021. This Court's June 29 grant of certiorari in *Rush Prudential* suggests that neither the circuit split involved in that case nor the related but different split involved in this case should go unresolved just because of the possibility of legislation. In any event, as of the date of the filing of this petition, the prospects for new legislation in the near future are

Numerous commentators have noted that "lower courts have struggled, in vain, to find a manageable framework * * * through which they could apply ERISA preemption to claims against HMOs. The result has been a panoply of confusion among courts, HMOs, physicians, and subscribers * * *." B. Richardson, *Health Care: ERISA Preemption and HMO Liability — A Fresh Look at ERISA Preemption in the Context of Subscriber Claims Against HMOs*, 49 OKLA. L. REV. 677, 679 (1996). The "myriad of confusion" that now exists in the federal and state courts with respect to the proper application of ERISA preemption to tort claims against HMOs "has served to erode the public trust of HMOs, government, and the judicial system." *Id.* at 701.

"With no specific guidance from the Supreme Court in this area, lower courts have floundered and strained," and "there is no consistency in the logic courts have applied, and therefore no clarification of the scope of ERISA pre-emption." R. Charrow & L. Greenlees, *ERISA Pre-emption — A Law in Search of a Doctrine*, HEALTH LAW DIGEST, March 1999, at 10. The authors conclude as follows:

> Until the Supreme Court addresses the ERISA pre-emption issue, healthcare attorneys can expect three things. First, there will be an increase in the frequency of federal appeals court decisions devoted to ERISA pre-emption issues. Second, the courts will continue to struggle by drawing distinctions — some meaningful, some not — in the hope of reaching results that are both equitable and in accord

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doubtful. See *White House Tries to Influence Debate on Patients' Bill of Rights Legislation*, 70 U.S.L.W. 2042 (July 17, 2001) (although S. 1052 has passed the Senate, President Bush has threatened to veto it "on grounds that it provides for far too broad an expansion of the scope for lawsuits," and competing bills are pending in the House, making the entire outcome as well as its intermediate steps quite unclear); Amy Goldstein & Juliet Eilperin, *Bush Lobbies Hill On Patient Rights*, WASH. POST, July 27, 2001, at A1 (reflecting postponement of House vote and uncertainty of timing of future House consideration).

> with the broad pre-emption provision. Third, the mass of appeals court decisions will be of little help; it will still be difficult for any tort litigant to predict with any degree of certainty the outcome of most ERISA pre-emption cases. It is this uncertainty that makes ERISA pre-emption a complex and tense issue in need of Supreme Court guidance.

Id. at 14. Accord K. Jordan, *Travelers Insurance: New Support for the Argument to Restrain ERISA Pre-emption*, 13 YALE J. ON REG. 255, 304 (1996) ("the outcomes on the issue of ERISA preemption [of tort claims against HMOs] have been inconsistent — indeed, the situation might be characterized as one of utter confusion on the issue"); K. Bartholomew, *ERISA Preemption of Medical Malpractice Claims in Managed Care: Asserting a New Statutory Interpretation*, 52 VAND. L. REV. 1131, 1133 (1999) (noting "doctrinal confusion and 'chaos' in the lower courts," with the result that "[l]ittle judicial guidance * * * currently exists for interpreting ERISA's poorly constructed preemption clause"); P. Jacobson & S. Pomfret, *Form, Function and Managed Care Torts: Achieving Fairness and Equity in ERISA Jurisprudence*, 35 HOUS. L. REV. 985, 1032 (1998) (decisions considering ERISA preemption of tort claims against HMOs have been marked by "instability, unpredictability, and a lack of uniformity — exactly the problem Congress intended the preemption clause to cure"); Note, *You Can't Get There From Here — Questioning the Erosion of ERISA Preemption in Medical Malpractice Actions Against HMOs*, 30 GA. L. REV. 1023, 1051 (1996) ("these various approaches have created incongruity and analytical inconsistency among courts").

Pegram has hardly solved the problem. Although there are those who (perhaps opportunistically) purport to find hidden in *Pegram* clear guidance about preemption — even though preemption was *not* at issue in *Pegram* — others correctly observe that, "[a]fter *Pegram*, the limits of ERISA preemption are as murky as ever, with the Supreme Court's opinion casting as

much shadow as light on an issue that has long cried out for resolution." A. Rosoff, *Breach of Fiduciary Duty Lawsuits Against MCOs: What's Left After Pegram v. Herdrich?*, 22 J. LEGAL. MED. 55, 56 (2001); see also *ibid.* ("judicial clarification * * * [is] still sorely needed"); *id.* at 75 ("the *Pegram* decision gives mixed and conflicting signals"). The conflict between the decision below and *Pryzbowski* reflects the inevitability of continued discord in the lower courts, post-*Pegram*, unless this Court steps in. See also Brief for the United States as Amicus Curiae 17-19 & nn.5-6 (June 2001), *Montemayor* v. *Corporate Health Ins., Inc.*, No. 00-665, and *Rush Prudential HMO, Inc.* v. *Moran*, No. 00-1021 (recognizing conflict between decision below and *Pryzbowski*; framing the question as "what effect, if any, *Pegram*'s discussion of ERISA's fiduciary responsibilities has on ERISA preemption analysis"; observing that "[t]he answer to that question could be of very broad significance"; and repeating that "the question concerning the effect, if any, of *Pegram* on ERISA preemption analysis could have very broad implications").[10]

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[10] There is a sufficient overlap between the issues on which the Court has granted certiorari in *Rush Prudential* and the issues raised by this petition that this case should at least be held pending the disposition of *Rush Prudential*, yet the cases also are sufficiently different that an outright grant rather than a hold would be better. On the one hand, both cases pose the question whether *Pegram*, which was a fiduciary duty case and not a preemption case, changes preemption analysis at all. As the quotations in the text show, the United States — despite the brief it filed in the Pennsylvania Supreme Court — now seems to be signaling this Court that it has grave doubts that *Pegram* has "any" "effect * * * on ERISA preemption analysis." 00-665 U.S. Br. 18. On the other hand, the existence of the necessary "relat[ion] to" an ERISA plan was accepted by the Court below in *Rush Prudential*, whereas the existence of such a relation is what is at issue in this case. See *Moran* v. *Rush Prudential HMO, Inc.*, 230 F.3d 959, 968 (7th Cir. 2000). *Rush Prudential* seems likely to turn more on the insurance savings clause of ERISA, 29 U.S.C. § 1144(b)(2)(A), than on the construction of 29 U.S.C. §§ 1132(a) and 1144(a) at issue here. Compare 230 F.3d at 969-973 (construing insurance savings clause to have dispositive effect in that case), with 98-1836 U.S. Br. 14 n.10 ("this case [*Pappas*] does not involve ERISA's insurance savings clause or its construction in *Pilot Life*").

ERISA preemption in the context of negligence claims against managed health care companies is an important and recurring issue that will continue to perplex and divide the federal and state courts until this Court finally steps in and provides much-needed guidance and clarity. This case offers an excellent opportunity to the Court to assist the lower courts in grappling with this difficult issue. Indeed, legal commentators have described the decision in *Pappas II* as one whose "implications * * * are 'enormous'"[11] and as potentially "the case everyone is waiting for" to secure this Court's review.[12]

CONCLUSION

The petition for writ of certiorari should be granted.

Respectfully submitted,

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[11] *On Remand From U.S. Supreme Court, Pennsylvania Finds No ERISA Bar To Suit*, 10 HEALTH LAW REP. (BNA) 592, 593 (Apr. 12, 2001).

[12] M. Morrissey, *An HMO Tale of Rashomon*, NAT'L L.J., June 18, 2001, at A1, A17.

APPENDIX A

Supreme Court of Pennsylvania.

In re Basil PAPPAS and Theodora Pappas, H/W, Plaintiffs,
v.
David S. ASBEL, D.O., Defendant.
Pennsylvania Hospital Insurance Co. (PHICO) and The Commonwealth of
Pennsylvania Medical Professional Liability Catastrophe Loss Fund (Cat Fund),
Defendants/Appellees.
United States Healthcare System of Pennsylvania, Inc.,
Additional
Defendant/Appellant.

Submitted Aug. 29, 2000.
Decided April 3, 2001.

Before: FLAHERTY, ZAPPALA, CAPPY, CASTILLE, NIGRO, NEWMAN and SAYLOR, Justices

OPINION

CAPPY, Justice.

Based on the principles the United States Supreme Court articulated in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 115 S.Ct. 1671, 131 L.Ed.2d 695 (1995), we issued an opinion in the instant case on December 23, 1998, holding that the state law medical negligence claims asserted against third-party defendant United States Healthcare Systems of Pennsylvania, Inc. ("U.S. Healthcare") are not preempted by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C.

1001 *et seq. Pappas v. Asbel*, 555 Pa. 342, 724 A.2d 889 (1998) ("*Pappas I* "). Accordingly, we affirmed the Superior Court's order, reversing the trial court's entry of summary judgment in U.S. Healthcare's favor. *Id.* at 894.[1] On June 19, 2000, the Supreme Court entered an order granting certiorari in *Pappas I*, vacating the judgment of this court, and remanding the case for our further consideration in light of *Pegram v. Herdrich*, 530 U.S. 211, 120 S.Ct. 2143, 147 L.Ed.2d 164 (2000). For all the reasons that follow, we adhere to our original opinion and order.

The facts and procedural history, as set forth in *Pappas I*, bear repeating.

> At 11:00 a.m. on May 21, 1991, Basile Pappas ("Pappas") was admitted to Haverford Community Hospital ("Haverford") through its emergency room complaining of paralysis and numbness in his extremities. At the time of his admission, Pappas was an insured of HMO-PA, a health maintenance organization operated by U.S. Healthcare.
>
> Dr. Stephen Dickter, the emergency room physician, concluded that Pappas was suffering from an epidural abscess which was pressing on Pappas' spinal column. Dr. Dickter consulted with a neurologist and a

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[1] Our reasons for finding against ERISA preemption differed from those relied upon by the Superior Court. The Superior Court was of the view that considerations of cost containment that drive HMO decisions did not exist when Congress enacted ERISA. *Pappas v. Asbel*, 450 Pa.Super. 162, 675 A.2d 711, 716 (1996). The Superior Court concluded, therefore, that Congress could not have intended to preempt that which it did not know would come into existence. *Id.* Inasmuch as one year preceding the enactment of the statute, Congress passed the Health Maintenance Organization Act of 1973, 42 U.S.C. § 300e *et seq.*, we could not agree that HMOs were unforeseen by Congress when it drafted ERISA. *Pappas I*, 724 A.2d at 893 n. 6.

neurosurgeon; the physicians concurred that Pappas' condition constituted a neurological emergency. Given the circumstances, Dr. Dickter felt that it was in Pappas' best interests to receive treatment at a university hospital.

Dr. Dickter made arrangements to transfer Pappas to Jefferson University Hospital ("Jefferson") for further treatment.

At approximately 12:40 p.m. when the ambulance arrived, Dr. Dickter was alerted to the fact that U.S. Healthcare was denying authorization for treatment at Jefferson. Ten minutes later, Dr. Dickter contacted U.S. Healthcare to obtain authorization for the transfer to Jefferson. At 1:[05]p.m., U.S. Healthcare responded to Dr. Dickter's inquiry and advised him that authorization for treatment at Jefferson was still being denied, but that Pappas could be transferred to either Hahnemann University ("Hahnemann"), Temple University or Medical College of Pennsylvania ("MCP").

Dr. Dickter immediately contacted Hahnemann. That facility advised Haverford at approximately 2:20 p.m. that it would not have information on its ability to receive Pappas for at least another half hour. MCP was then reached and within minutes it agreed to accept Pappas; Pappas was ultimately transported there at 3:30 p.m. Pappas now suffers from permanent quadriplegia resulting from compression of his spine by the abscess.

Pappas and his wife filed suit against Dr. David Asbel, his primary care physician, and Haverford. They claimed that Dr. Asbel had committed medical malpractice and that Haverford was negligent in causing an inordinate delay in transferring him to a facility equipped and immediately available to handle his neurological emergency.

Haverford then filed a third party complaint against U.S. Healthcare, joining it as a party defendant for its refusal to authorize the transfer of Pappas to a hospital selected by the Haverford physicians. Dr. Asbel also filed a cross-claim against U.S. Healthcare seeking contribution and indemnity.

U.S. Healthcare filed a motion for summary judgment on all of the third party claims, alleging that the third party claims are preempted by § 1144(a) of ERISA.[1] The trial court granted the motion.[2] The Superior Court on appeal, however, determined that ERISA did not preempt the state law claims. This court subsequently granted U.S. Healthcare's Petition for Allowance of Appeal in order to determine whether these third party claims fall within the scope of those state actions which are preempted by ERISA.

[1] It is uncontested that U.S. Healthcare is an "employee benefits plan" pursuant to ERISA, 29 U.S.C. § 1002(1), and that ERISA therefore applies to this matter.

[2] Approximately one year after the trial court granted summary judgment in U.S. Healthcare's favor, Dr. Asbel and Haverford settled the actions brought against them. They have been substituted in this appeal by their insurers, Pennsylvania Hospital Insurance Co. ("PHICO") and the Commonwealth of Pennsylvania Medical Professional Liability Catastrophic Loss Fund ("CAT Fund").

Pappas I, 724 A.2d at 889-91.

Our legal analysis in *Pappas I* began with a review of the basic principles of preemption law. We noted that the

Supremacy Clause of the United States Constitution, U.S. Const., art. VI, cl. 2, gives the United States Congress the power to preempt state law, and observed that in determining whether state law is preempted by federal law, we were to assume that the historic powers of the states are not superceded [*sic*] unless preemption is the "clear and manifest purpose" of Congress. *Id.* at 891 (*quoting Cipollone v. Liggett Group*, 505 U.S. 504, 516, 112 S.Ct. 2608, 120 L.Ed.2d 407 (1992)) (citations omitted).

Turning to the express preemption section of ERISA, which states that "the provisions of this subchapter ... shall supercede [*sic*] any and all State laws insofar as they may now or hereafter relate to any employee benefit plan....", 29 U.S.C. § 1144(a), we recognized that in the 1980's and early 1990's, the Supreme Court had given ERISA preemption a notably expansive scope based on the plain language of this section. *Pappas I*, 724 A.2d at 891-92. With its 1995 decision in *Travelers*, however, we determined that the Court had signaled a change in course, instructing the courts to look to the objectives of ERISA, and not solely to the bare, "unhelpful" text of the statute, for guidance in deciding questions of preemption. *Id.* at 892, (*quoting Travelers*, 514 U.S. at 656, 115 S.Ct. 1671). We deemed it significant that the Court determined that the "basic thrust of the preemption provision ... was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans"; that it recognized fairly significant bounds on preemption when it stated that "[p]re-emption does not occur ... if the state law has only a tenuous, remote, or peripheral connection with covered plans, as in the cases with many laws of general applicability"; and that it cautioned that "nothing in the language of [ERISA] or in the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern." *Id.* at 892 (*quoting Travelers*, 514 U.S. at 661, 115 S.Ct. 1671).

Applying *Travelers* and its progeny, *California Division of Labor Standards Enforcement v. Dillingham Construction NA., Inc.*, 519 U.S. 316, 117 S.Ct. 832, 136 L.Ed.2d 791 (1997) and *De Buono v. NYSA-ILA Medical and Clinical Services Fund*, 520 U.S. 806, 117 S.Ct. 1747, 138 L.Ed.2d 21 (1997), to the case *sub judice*, we determined that the negligence claims in plaintiffs' complaint, which Haverford incorporated by reference against U.S. Healthcare in its third party complaint, are not preempted. *Pappas I*, 724 A.2d at 894.[2] We found that they do not "relate to" an ERISA plan within the meaning of 29 U.S.C. § 1144(a), and that local negligence laws, like many laws of general applicability, are only remotely connected to ERISA plans. *Id.* at 893, 894. In view of the Supreme Court's determination that Congress did not intend to preempt state laws aimed at regulating health care, we held it would have been inappropriate to conclude that Haverford's claims, in which the issue of U.S. Healthcare's allegedly dilatory delivery of contractually-guaranteed medical benefits were intertwined with the question of safe medical care, are preempted by ERISA. *Id.* at 893.[3]

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[2] Haverford asserted the following allegations from plaintiffs' complaint against U.S. Healthcare:

24. The negligence of [Haverford] ... consisted of the following:

a. Failing to transfer the patient to a hospital capable and competent of administering to his acute medical condition in a prompt and timely fashion;

b. Delaying inordinately in transferring the patient, keeping him at [Haverford] during which time his spinal cord compression continued, with resulting permanent damage to the patient's spinal cord.

Complaint, para. 24.

[3] Justice Nigro filed a concurring opinion. In Justice Nigro's view,

We now turn, as instructed by the Supreme Court, to a reconsideration of our decision in *Pappas I* in light of *Pegram*. We start with a somewhat detailed rendition of *Pegram's* facts, as they are critical to our present task. The case arose out of a lawsuit brought by Cynthia Herdrich against her treating physician, Dr. Lori Pegram, and the health maintenance organization ("HMO") that Dr. Pegram and her partners owned and operated. The HMO had contracted with the company that employed Herdrich's husband to provide pre- paid medical services to its employees and their respective families. Dr. Pegram examined Herdrich for pain in the midline area of her groin, and discovered an inflamed mass in her abdomen. Dr. Pegram did not order an immediate ultrasound at the local hospital, but decided to wait some eight days for an ultrasound at a facility staffed by HMO physicians. Before the ultrasound could be performed, Herdrich's appendix ruptured, causing peritonitis.

Herdrich sued Dr. Pegram and the HMO in state court for medical malpractice, and later added two counts of state law fraud. Asserting that the fraud counts were preempted by ERISA, Pegram and the HMO removed the case to federal district court, and moved for summary judgment. The district court granted the defendants summary judgment on the first count, but granted Herdrich leave to amend the second. She did, alleging that the provision of medical services under the terms of the HMO, which rewarded its physician owners for limiting medical care, amounted to an inherent or anticipatory

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the facts demonstrated that "U.S. Healthcare's actions constituted, in effect, an individual medical decision or judgment as opposed to a decision affecting the administration of an employee benefit plan." *Pappas I*, 724 A.2d at 889. It can fairly be said that Justice Nigro's approach to the question of ERISA preemption in this case anticipated the Supreme Court's reasoning in *Pegram*.

breach of ERISA's fiduciary duties as set forth in 29 U.S.C. § 1109(a), to make decisions with the exclusive interest of plan participants in mind. The HMO moved to dismiss the ERISA count for failure to state a claim upon which relief could be granted. Finding that the HMO was not involved in the events at hand as an ERISA fiduciary, the district court sustained the motion. The Court of Appeals for the Seventh Circuit reversed.

The Supreme Court granted certiorari to determine whether treatment decisions made by an HMO, acting through its physicians, are fiduciary acts within the meaning of ERISA. The Court held that they are not. *Pegram*, 530 U.S. 211, 120 S.Ct. at 2146.

In the course of doing so, the Court set forth two guiding principles. First, HMO physicians occupy dual roles. They act like plan administrators when they determine, for example, whether a participant's condition is covered, and as health care providers, when they decide upon the medical treatment a participant will receive. *Id.* at 2153-54.

Second, HMO physicians make three types of decisions. "[P]ure 'eligibility decisions' turn on the plan's coverage of a particular condition or medical procedure for its treatment," *id.* at 2154, such as "whether a plan covers an undisputed case of appendicitis." *Id.* at 2155. " 'Treatment decisions,' by contrast, are choices about how to go about diagnosing and treating a patient's condition: given a patient's constellation of symptoms, what is the appropriate medical response?" *Id.* at 2154. "Mixed eligibility and treatment decisions" are just what their name implies-decisions in which coverage and medical judgment are intertwined. *Id.* at 2154-55. In this regard, the Court explained:

> [A] great many and possibly most coverage questions are not simple yes-or-no questions, like whether appendicitis is a covered condition (when there is no dispute that a patient has appendicitis), or whether

> acupuncture is a covered procedure for pain relief (when the claim of pain is unchallenged). The more common coverage question is a when-and-how question. Although coverage for many conditions will be clear and various treatment options will be indisputably compensable, physicians still must decide what to do in particular cases.... In practical terms, these eligibility decisions cannot be untangled from physicians' judgments about reasonable medical treatment....

Id. at 2154.

To illustrate the wide array of decisions that are of the mixed type, the Court noted the decisions mentioned in Herdrich's complaint: "physician's conclusions about when to use diagnostic tests; about seeking consultations and making referrals to physicians and facilities other than [the HMO's]; about proper standards of care, the experimental nature of a proposed course of treatment, the reasonableness of a certain treatment and the emergency character of a medical condition." *Id.* at 2155.

Turning to the case at hand, the Court found that the HMO, through Dr. Pegram, made a mixed decision, "decid[ing] (wrongly, as it turned out) that Herdrich's condition did not warrant immediate action; the consequence of that medical determination was that [the HMO] would not cover immediate care, whereas it would have done so if Dr. Pegram had made the proper diagnosis and judgment to treat." *Id.* at 2154.

The Court then held that Congress did not intend that any HMO be treated as an ERISA fiduciary to the extent that it makes mixed eligibility and treatment decisions acting through its physicians. *Id.* at 2155.[4] Observing that under the common

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[4] The HMO in *Pegram* was owned by its physicians. U.S. Healthcare contracts with independent physicians to provide services. *Pegram*'s

law of trusts, which is the source of ERISA's fiduciary duties, fiduciary responsibility characteristically attaches to financial decisions about managing assets and property, the Court doubted that Congress would have ever thought of a mixed decision as fiduciary in nature. *Id.* at 2155-56. Because the defense of any HMO of a mixed decision would be that its physician acted for good medical reasons, the plausibility of which would require reference to traditional standards of reasonable medical practice in like circumstances, the Court was concerned that a decision to view a mixed decision as an act of ERISA fiduciary duty would "federalize malpractice litigation". *Id.* at 2157-58. Lastly, the Court touched upon (but declined to resolve) the "puzzling issue of preemption" that would be raised by the imposition of ERISA's fiduciary requirements upon an HMO physician making a pure treatment or mixed decision, in view of its holding in *Travelers*:

> On its face, federal fiduciary law applying a malpractice standard would seem to be a prescription for preemption of state malpractice law, since the new ERISA cause of action would cover the same subject of a state-law malpractice claim.... To be sure, [*Travelers*] throws some cold water in the preemption theory; there, we held that, in the field of health care, a subject of traditional state regulation, there is no ERISA preemption without clear manifestation of congressional purpose. But in that case the convergence of state and federal law was not so clear as in the situation we are positing; the state-law standard had not been subsumed by the standard to be applied under ERISA. We could

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result was based on the nature of the HMO's decision, not on the structure of the HMO making it. *Pegram*, 530 U.S. at 230-31, 120 S.Ct. at 2155. Further, the Supreme Court's holding was all-inclusive as to HMOs. *Id.* Thus, the difference in organization between the HMO in *Pegram* and U.S. Healthcare is not relevant to this analysis.

> struggle with this problem, but first it is well to ask, again, what would be gained by opening the federal courthouse doors to a fiduciary malpractice claim....

Pegram, at 2158 (citations omitted).

While *Travelers* and *Pegram* deal with different aspects of ERISA, for our present purposes, they share common ground. *Travelers* instructs that ERISA does not preempt state law that regulates the provision of adequate medical treatment. *Pegram* instructs that an HMO's mixed eligibility and treatment decision implicates a state law claim for medical malpractice, not an ERISA cause of action for fiduciary breach. Thus, if Haverford's third party claim against U.S. Healthcare arose out of a mixed decision, it is, according to *Pegram*, subject to state medical malpractice law, which is what Haverford asserted. Moreover, under *Travelers*, it is not preempted by ERISA.

It follows that we must now determine what the record on summary judgment reveals with regard to the nature of the U.S. Healthcare's decision. We view the record in the light most favorable to the non-moving party, and all doubts as to the existence of a genuine issue of material fact must be resolved against the moving party. *Pennsylvania State University v. County of Centre*, 532 Pa. 142, 615 A.2d 303, 304 (1992). Only where there is no genuine issue as to any material fact and it is clear that the moving party is entitled to a judgment as a matter of law will summary judgment be entered. *Skipworth v. Lead Industries Ass'n, Inc.*, 547 Pa. 224, 690 A.2d 169, 171 (1997). Our scope of review of a trial court's order granting or denying summary judgment is plenary, *O'Donoghue v. Laurel Savings Ass'n*, 556 Pa. 349, 728 A.2d 914, 916 (1999), and our standard of review is clear: the trial court's order will be reversed only where it is established that the court committed an error of law or abused its discretion. *Cochran v. GAF Corp.*, 542 Pa. 210, 666 A.2d 245, 248 (1995).

Having looked again at the record, there are facts that are not disputed, in addition to those set forth in *Pappas I*, that are important to our analysis. Dr. Dickter, the physician who first saw Pappas in the emergency room of Haverford on May 21, 1991, at about 11:00 a.m., received permission from Jefferson to admit Pappas to its spinal cord trauma center. Dr. Dickter chose Jefferson because it, unlike other hospitals, had designated space for spinal trauma cases and was able to determine immediately whether it was in a position to receive a new patient. When Dr. Dickter learned at 12:40 p.m. from ambulance personnel that Pappas' transfer to Jefferson was not HMO approved, he telephoned U.S. Healthcare at 12:50 p.m. and asked that it reconsider its decision. Dr. Dickter spoke to Elaine Norman, a U.S. Healthcare representative, and told her that Pappas' condition constituted a neurological emergency that needed immediate attention, and for which he had made arrangements with Jefferson. Ms. Norman advised Dr. Dickter that she was not authorized to take action one way or the other, but that she would consult with someone who was. At 1:05 p.m., Dr. Dickter spoke with Carol DeLark, another U.S. Healthcare representative. She told him that Dr. Liebowitz [*sic*], one of U.S. Healthcare's physicians who had the authority to decide such matters, reviewed Pappas' case; that the referral to Jefferson, a non-HMO hospital, continued to be denied; and that a referral to the facilities affiliated with Hahnemann, Temple University or MCP was approved. At about 3:30 p.m., through Dr. Dickter's efforts, Pappas was admitted to MCP.

Not surprisingly, U.S. Healthcare argues that its decision about Pappas' referral "constituted a quintessential 'coverage' determination".[5] We, however, disagree. In our view, the

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[5] A number of the statements U.S. Healthcare made when this appeal was originally heard do not reflect its present position that its decision was entirely devoid of medical judgment as to treatment. In its Reply Brief, for example, U.S. Healthcare stated that its "sole involvement in this matter was to answer a physician's question concerning what

undisputed facts in this case, and the inferences drawn from them, establish the sort of mixed eligibility and treatment decision that *Pegram* discussed.[6] Dr. Leibowitz, U.S. Healthcare's physician, reviewed Pappas' case, and rejected another medical doctor's opinion based on his clinical judgment that Pappas needed to be referred to Jefferson for treatment of a medical emergency. Instead of referring Pappas to Jefferson, a non-HMO hospital, as Dr. Dickter recommended, Dr. Leibowitz referred Pappas to one of three other facilities for medical care. He did not, in the Supreme Court's words, only make a "simple yes or no" decision as to whether Pappas' condition was covered; it clearly was. Rather, Dr. Leibowitz also determined where and, under the circumstances, when Pappas' epidural abscess would be treated. His was a mixed eligibility and treatment decision, the adverse consequences of which, if any, are properly redressed, as *Pegram* teaches, through state medical malpractice law. This law as *Travelers* teaches, is not preempted by ERISA.

We conclude, therefore, that our reasoning and result in *Pappas I* are consistent with the Supreme Court's decision in

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nearby hospitals were capable of treating the patient's condition." (Reply Brief for Appellant at 2). Later, U.S. Healthcare recited that it "advised Dr. Dicker of three HMO PA participating hospitals in the area–Hahnemann, Temple and MCP–that could provide the same treatment available at Jefferson." (Reply Brief for Appellant at 4).

[6] We need not remand this matter for further findings. The record is undisputed and clear on the basic facts. Moreover, an appellate court may draw its own inferences from basic facts and arrive at its own conclusions when a finding of fact is simply a deduction from other facts and the ultimate fact in question is purely a result of reasoning. *Hutchison v. Sunbeam Coal Corp.*, 513 Pa. 192, 519 A.2d 385, 391 n. 6 (1986). The question of a decision's type--eligibility, treatment or mixed--is this sort of "ultimate fact", deduced from the basic facts through reasoning.

Pegram. Accordingly, we confirm our original disposition; the order of the Superior Court, reversing the grant of summary judgment to U.S. Healthcare is affirmed.[7] This matter is

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[7] With due respect to our learned colleague, we believe the dissent gives our analysis too broad a reading, and, it would seem, bases its disagreement with our holding on a question not raised in this appeal.

With regard to our analysis, there is no reason for concern that from this point forward, conflict preemption issues arising under ERISA will include no more than the "mere identification of whether a fiduciary act was involved". (Dissenting Opinion at 11). Our analysis of ERISA preemption in *Pappas I* was founded on the preemption provision of the statute, 29 U.S.C. 1144(a), and the Supreme Court's most recent teaching on the matter. This analysis, of course, continues to apply. It was the Supreme Court's request that we consider our decision in *Pappas I*, in light of its decision in *Pegram*, that necessitated our finding the conceptual relationship between a claim for breach of ERISA's fiduciary duties and the assertion that a state law claim for medical malpractice is preempted.

Turning to the main focus of the dissent, we read it as stating that this court should articulate a new and definitive duty or standard of care for HMO physicians making mixed eligibility and treatment decisions, and until that task is completed, issues of ERISA preemption cannot be resolved. Preliminarily, we note that the issue of duty or standard of care is not before us. We granted allocatur to consider U.S. Healthcare's motion for summary judgment, in which it asserted that the third party state law medical malpractice claims brought against it are preempted by ERISA *per se*. Whether the element of duty or the standard of care to which U.S. Healthcare should be held when third party plaintiffs attempt to prove their case differs from the duty or standard of care that Pennsylvania law imposes on non-HMO physicians is an issue that may remain for another day.

Moreover, the question the dissent poses conceivably presents a "Catch-22" form of circular reasoning. That is to say, any answer leads to ERISA preemption. On the one hand, according to the

remanded to the trial court for further proceedings consistent with this opinion.

Mr. Justice Saylor files a dissenting opinion.

SAYLOR, Justice, dissenting.

In response to the United States Supreme Court's remand directive for this Court to reconsider its prior decision in *Pappas v. Asbel*, 555 Pa. 342, 724 A.2d 889 (Pa. 1998) ("*Pappas I* "),[1] in light of *Pegram v. Herdrich*, 530 U.S. 211, 120 S.Ct. 2143, 147 L.Ed.2d 164 (2000)("*Pegram II*"), the majority concludes that *Pegram II* establishes that the third-party cause of action against Appellant United States Healthcare Systems of Pennsylvania, Inc. ("U.S. Healthcare") is not preempted by ERISA, and that such cause should therefore be resolved according to state medical malpractice law. In so holding, the majority finds that *Pegram II 's* conclusion that ERISA does not establish a cause of action for breach of fiduciary duty predicated upon a managed care organization's "mixed eligibility" decisions, *see Pegram II*, 530 U.S. at 228-

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dissent, the application of a standard of care to an HMO's mixed eligibility and treatment decision that does not take into account an HMO's way of doing business arguably has more than a "tenuous, remote, or peripheral connection" with a covered plan, *Travelers*, 514 U.S. at 661, 115 S.Ct. 1671, and thus, is preempted. On the other hand, however, if a special standard of care is articulated for evaluating those decisions in which the peculiar pressures of an HMO's rationing decisions are considered, such a rule arguably regulates a plan's administration, and is also preempted. Under either scenario, ERISA invariably preempts a state law claim for medical malpractice arising out of an HMO's mixed eligibility and treatment decision. In our view, *Travelers* and *Pegram* do not contemplate such a result.

[1] I did not participate in the decision in *Pappas I*, as it was argued prior to my induction onto this Court.

29, 120 S.Ct. at 2154-55, equally establishes that such decisions are fully exposed to state tort law.

While I agree with the majority that nothing in *Pegram II* requires a full reversal of its prior disposition, I note that other courts have been more circumspect concerning the implications of *Pegram II* in relation to conflict preemption pursuant to ERISA. *See, e.g., Corporate Health Ins., Inc. v. Texas Dep't of Ins.*, 220 F.3d 641, 643-44 (5th Cir.2000) (stating that "we do not read *Pegram* to entail that every conceivable state law claim survives preemption so long as it is based on a mixed question of eligibility and treatment, and [our own precedent] held otherwise"). Accordingly, there remains a division of authority regarding the appropriate construct pursuant to which ERISA preemption of laws regulating the decisions of managed care organizations should be determined,[2]

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[2] *Compare Bauman v. U.S. Healthcare, Inc.*, 193 F.3d 151 (3d Cir.1999), *cert. denied*, 530 U.S. 1242, 120 S.Ct. 2687, 147 L.Ed.2d 960 (2000); *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350 (3d Cir.1995); *Pacificare of Oklahoma v. Burrage*, 59 F.3d 151 (10th Cir.1995), *with Hull v. Fallon*, 188 F.3d 939 (8th Cir.1999), *cert. denied*, 528 U.S. 1189, 120 S.Ct. 1242, 146 L.Ed.2d 101 (2000); *Danca v. Private Health Care Systems, Inc.*, 185 F.3d 1, 5-7 (1st Cir.1999); *Parrino v. FHP, Inc.*, 146 F.3d 699, 705 (9th Cir.), *cert. denied*, 525 U.S. 1001, 119 S.Ct. 510, 142 L.Ed.2d 423 (1998); *Turner v. Fallon Community Health Plan*, 127 F.3d 196 (1st Cir.1997); *Jass v. Prudential Health Care Plan Inc.*, 88 F.3d 1482 (7th Cir.1996); *Tolton v. American Biodyne, Inc.*, 48 F.3d 937 (6th Cir.1995); *Kuhl v. Lincoln Nat'l Health Plan*, 999 F.2d 298 (8th Cir.1993); *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321 (5th Cir.1992). Although it has been suggested that the reasoning from *Pegram II* has effectively overruled the latter line of decisions, reserving ERISA preemption exclusively for the narrow category of claims implicating pure eligibility determinations by an HMO unrelated to medical diagnosis and decision making, the assessment in the aftermath of *Pegram II* has remained mixed. *See, e.g., Corporate Health*, 220 F.3d at 643- 44; *Schusteric v. United*

although further examination of this divide is beyond the scope of our mandate on remand. I do believe, however, that two points derive from *Pegram II* that are worthy of present consideration.

First, in my view, *Pegram II* gives cause for the exercise of a degree of caution on the part of state courts and legislators in terms of defining the duties of managed care organizations (or at least those that are deemed to perform administrative functions under ERISA) for purposes of tort jurisprudence. Second, I question whether a full, fair, and final resolution of the conflict preemption inquiry can be effected unless and until some more precise definition is afforded to any duties being ascribed to U.S. Healthcare under state tort law.

Regarding the first of these points, if ERISA preemption issues can arise only in connection with a specific exercise of fiduciary duty, the majority is correct that, once U.S. Healthcare's decision is deemed to be a mixed eligibility determination,[3] *Pegram II* establishes the absence of a fiduciary

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Healthcare Ins. Co., 2000 WL 1263581 (N.D.Ill. Sept.5, 2000).

[3] While U.S. Healthcare has argued that its decision to deny precertification of Mr. Pappas' transfer was a pure eligibility determination, the majority's conclusion that it was in fact a "when-and- how" sort of decision within the contemplated scope of the United States Supreme Court's framing of mixed eligibility decisions, *see Pegram II*, 530 U.S. at 228, 120 S.Ct. at 2154, finds a degree of support in *Pegram*. It should be noted, however, that the decision made in *Pappas* was far closer on the continuum to the eligibility form than that which was at issue in *Pegram*, since, under U.S. Healthcare's modified- IPA-style structure, the decision was not made by the actual treating physician as was the case under the capitated arrangement at issue in *Pegram*. Indeed, arguably an IPA-style HMO's decision whether to pay for out-of-network services touches the eligibility end of the spectrum, since in relation to out-of-network providers, the HMO no longer itself functions as a service provider

duty under ERISA, and preemption cannot apply. Certainly, however, the preemption clause itself is more broadly phrased; further, ERISA's civil enforcement provision, 29 U.S.C. § 1132, would appear to have been designed to protect the interests of plan participants more generally. Thus, while it is clear that the United States Supreme Court now subscribes to a narrower concept of preemption than that reflected in its earlier decisions, I am not so certain that the question of whether a state law claim challenges a fiduciary act is the sole, remaining, pertinent inquiry relative to preemption, particularly where the defendant may otherwise perform servicing functions integral to plan administration.

Accordingly, I would examine *Pegram II's* analysis more broadly than merely to identify the construct which it ultimately devised to determine fiduciary status. I view as significant the Supreme Court's deliberate, measured reasoning addressing and rejecting the central conclusions of the Seventh Circuit concerning an HMO's obligations under federal law,[4] with the Court's analysis subsuming the assessment that the duty of a

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through its pre-arranged contracts, but rather, is relegated to a traditional fee-for-service insurance function. *See generally Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266, 2001 WL 292997, 2001 U.S.App. LEXIS 4903 (3d Cir. Mar. 27, 2001)(holding that a delay-in-approval claim against U.S. Healthcare fell squarely within the realm of the HMO's administrative function).

[4] The Seventh Circuit had determined that an HMO's cost control incentive system or structure could serve as the predicate for a claim of breach of fiduciary duty under ERISA. *See Herdrich v. Pegram*, 154 F.3d 362, 373 (7th Cir.1998). In so holding, the majority employed strong language that was condemnatory of various HMO practices. *See, e.g., id.* at 375 (stating that "[i]n order to minimize health care costs and fatten corporate profits for HMOs, primary care physicians face severe restrictions on referrals and diagnostic tests, and at the same time, must contend with ever-shrinking incomes").

managed care organization as stated by the Seventh Circuit was inimical to Congressional intent in fostering the health maintenance organization paradigm. *See generally* Phyllis C. Borzi and Marc I. Machiz, *ERISA and Managed Care Plans: Key Preemption and Fiduciary Issues,* SF28 ALI-ABA 371 (ALI-ABA Course of Study Oct. 2000) (stating that "[t]he Court in *Pegram* believed it faced an irreducible challenge to the essence of managed care"). Such rejection should not be overlooked, since, although the United States Supreme Court was discussing the issue of duty according to the federal fiduciary standard embodied in ERISA, state law duties which operate similarly would be no less disruptive. Moreover, the persistence of multiple state law standards broadly affecting otherwise permissible "rationing" decisions of managed care organizations, to the extent that such entities are viewed as serving as an important tool of plan administration, would also operate contrary to a central purpose of ERISA preemption, namely, to "avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans." *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 657, 115 S.Ct. 1671, 1677-78, 131 L.Ed.2d 695 (1995). Thus, although certainly the dicta employed by the United States Supreme Court concerning preemption would appear to evidence its conclusion that ERISA may embody a degree of tolerance for some divergence among the legal standards applicable to managed care organizations across jurisdictions, *see, e.g., Pegram II*, 530 U.S. at 236- 37, 120 S.Ct. at 2158,[5] such passages should not be read as

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[5] Differing causes of action which have been asserted against managed care organizations across the nation include medical malpractice, negligence, breach of contract, breach of implied covenant of good faith and fair dealing, intentional/negligent infliction of emotional distress, wrongful death, unfair business practices, defamation, interference with contractual relations between physician and patient, antitrust violations, ostensible agency, and vicarious liability. *See* Comment, *The Ultimate Jigsaw Puzzle: ERISA*

completely independent of the Court's disapproval of standards that would penalize HMOs based solely upon their structure and/or system for doing business.[6]

Preemption and Liability in the Utilization Review Process, 28 CUMB.L.REV. 403, 410 (1997-1998).

[6] In *Pryzbowski*, the Third Circuit recently made the above point as follows in relation to a delay-in-approval claim against an HMO:

A holding that Pryzbowski's claims against U.S. Healthcare are not completely preempted would open the door for legal challenges to core managed care practices (e.g., the policy of favoring in-network specialists over out-of-network specialists), which the Supreme Court eschewed in *Pegram*. *Cf.* 120 S.Ct. at 2156-57 (rejecting claims attacking financial incentives behind HMO structure, in light of congressional policy of promoting HMOs). *Pryzbowski*, 245 F.3d at ----. It should be noted that *Pegram II* tied various of its conclusions to the observation that the plaintiff had not alleged physical injury in the pertinent count of her complaint. Although this factor creates a substantial distinction between the claim under consideration in *Pegram* and that at issue here, I do not believe that the Court's concerns regarding allowance of the managed care form of business are completely inapposite when considering state law duties. Significantly, the particular framing of the count at issue in *Pegram* would appear to have been a consequence of the plaintiff's attempt to state a damages claim under ERISA (notably the plaintiff's overall complaint included allegations of concrete physical injury, including peritonitis). But just as a state law negligence claim can be recast in the form of a claim under ERISA, so the form of claim that the Supreme Court rejected as a matter of ERISA fiduciary analysis can effectively be restyled as a state law claim, and it is not a difficult matter to include an allegation of proximate harm in a forum with general jurisdiction to redress such injury. Indeed, several circuit courts of appeals have viewed various efforts to craft state law causes of action in just such a manner. *See, e.g., Jass*, 88 F.3d at 1489; *Schusteric*, 2000 WL 1263581.

As the United States Supreme Court recognized, fundamentally, managed care organizations ration treatment (or at least payment for treatment); assuming treatment is generally of positive effect, less treatment equates to greater risk (also assuming that patients cannot or will not fund treatment for which managed care will not pay);[7] and greater risk means higher incidence and more detrimental effect of injury and illness. If state law duties are imposed such that managed care organizations must provide compensation for all harm which can be proximately related to rationing, their viability will be determined by whether the cost of such harm ultimately exceeds the savings achieved by rationing in the first instance. Although certainly this is one form of risk spreading, it would not seem to be the form that Congress likely envisioned by sanctioning the managed care paradigm. Further, assuming that the managed care concept that has become integral as a service to ERISA plan administration is actually beneficial (as Congress appears to have believed), if costs ultimately exceeded savings in this particular equation, such benefit would be undermined. It would be difficult, then, to characterize state laws regulating rationing determinations which do not provide some reasonable mechanism for distinguishing between acceptable and unacceptable decisions as having only a "tenuous, remote, or peripheral connection" with covered plans, *Travelers*, 514 U.S. at 661, 115 S.Ct. at 1680, assuming that the element of plan administration extends to managed care services to ERISA plans.

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[7] I recognize that various managed care strategies such as preventative care are designed to decrease costs by providing timely interventions which may obviate the need for more expensive treatment in the long term. Obviously, it would be ideal if such strategies sufficiently reduced the cost of health care to maintain profitability without other forms of more direct rationing. The Supreme Court's opinion seemed to accept, however, that, at least in the short term, broader forms of rationing are necessary to the managed care concept.

This leads to my second point, namely, that before a matter of conflict preemption can be finally determined in relation to a common law duty, the state courts should define, with reasonable particularity, the pertinent duty with which the managed care organization is to be charged.[8] Here, the third-party complaint frames a cause of action for "refus[ing] to authorize transfer of husband-plaintiff to a hospital selected by physicians at Haverford Community Hospital as being able to minister to husband-plaintiff's condition." Pertinent to such claim, the majority merely indicates that the United States Supreme Court has sanctioned the application of general principles of medical malpractice to managed care organizations. The result is to insulate the majority's holding that preemption is unwarranted within the United States Supreme Court's analysis from *Travelers* that "nothing in the language of [ERISA] or in the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern." *Travelers*, 514 U.S. at 661, 115 S.Ct. at 1680. It should be recognized, however, that the asserted obligation of U.S. Healthcare to telephonically precertify out-of-network care on an emergency basis as selected by Haverford Community Hospital is not easily susceptible to measurement according to the general standard of care prevailing in the medical community pertaining to the rendition of medical services. In the first instance, medical personnel are not

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[8] In contrast, when the doctrine of complete preemption is asserted pursuant to Section 502 of ERISA in order to invoke federal jurisdiction, the plaintiff's well-pleaded complaint controls, since the analysis entails a comparison between a specific, federal cause of action and one asserted under state law. *See generally Bauman*, 193 F.3d at 160. A claim of conflict preemption under Section 514, however, asserted as a defense in a state court, questions whether a state law relates to ERISA, *see id.* Therefore, it is critically important in the Section 514 context that the pertinent state law obligation at issue be reasonably identified.

generally obligated to pay for medical services.[9] Further, U.S. Healthcare's obligations in respect to payment arise, at least initially, from its written commitments pertaining to the provision of health care services rather than from the general nature of a physician/patient relationship; thus, while managed care coverage is frequently comprehensive and must include access to emergency treatment, an HMO may not always commit (or pre-commit) to provide full payment for any and all services rendered on precisely the terms that may be dictated by the patient, a treating physician, or circumstance.[10] Additionally, by

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[9] The conclusions that physicians (or at least those not operating under a capitated arrangement) would not generally make decisions committing to payment responsibility finds at least colloquial support in the deposition testimony of the emergency-room physician who treated Mr. Pappas, who stated as follows:

A: My role as an emergency room physician is during an emergency to provide the best care, and I did not pay attention and did not concern myself with what would limit that care. I was trying to provide the best care for this patient. So did I, in an emergency situation, wonder whether the insurance was one over another? No.

Q: Well, was it your understanding that whether or not a patient has coverage doesn't affect whether or not a patient is treated, it just affects who pays for it after treatment is rendered?

A. From my point of view, the medicine comes first and the paperwork will be figured out later.

[10] One commentator argues this point as follows:
[T]here is powerful reason to recognize that a denial of funding does not *ipso facto* mean denial of care, nor is it necessarily the practice of medicine....

"[A]n adverse determination by a health insuring corporation means that the health insuring corporation will not pay for, reimburse, provide, deliver, arrange for, or otherwise make available the service in question.... It does not mean that the physician is precluded from

virtue of a managed care organization's assumption of the role of provider of or arranger for medical services, it may in fact assume additional duties giving rise to direct or indirect claims based in tort. In this regard, however, in Pennsylvania, the determination of duty in relation to a negligence cause of action is one of law subject to the following analysis:

> [T]he legal concept of duty of care is necessarily rooted in often amorphous public policy considerations, which may include our perception of history, morals, justice and society. The determination of whether a duty exists in a particular case involves the weighing of several discrete factors which include: (1) the relationship of the parties; (2) the social utility of the actor's conduct; (3) the nature of the risk imposed and foreseeability of the harm incurred; (4) the consequences of imposing a duty upon the actor; and (5) the overall public interest in the proposed solution.

Althaus v. Cohen, 562 Pa. 547, 553, 756 A.2d 1166, 1169 (2000).[11] While suggesting the direct application of medical

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providing the service or that the patient is precluded from obtaining the service from another source or through other means.... A physician or other provider retains authority to provide whatever services are deemed appropriate for the patient, even if the services are not included under the plan of the health insuring corporation." Morreim, *Managed Care Financial Structures,* 35 TORT & INS.L.J. at 709 (citation omitted). These comments, of course, must be read in light of constraints which may be imposed by legislative enactments and agency regulations establishing a floor for the HMO's duties, by the health care infrastructure, and by individual financial resources. The point here is only that the conclusion that full payment is always required solely upon proof of appropriateness should not be treated by courts as a foregone one.

[11] As the foundation for this summary, Mr. Justice Castille quoted from the Court's prior decision in *Sinn v. Burd*, 486 Pa. 146, 404 A.2d

malpractice principles to a non-traditional provider of insurance and medical services making mixed eligibility/treatment decisions, this Court has not undertaken the requisite duty analysis in *Pappas I* or presently. Indeed, aside from the Court's general categorization of precertification of emergency care as "intertwined with the provision of safe medical care," *Pappas I*, 555 Pa. at 351, 724 A.2d at 893, the question remains one of first impression in this Court.[12]

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672 (1979), as follows:

> In determining the existence of a duty of care, it must be remembered that the concept of duty amounts to no more than the "sum total of those considerations of policy which led the law to say that the particular plaintiff is entitled to protection" from the harm suffered.... To give it any greater mystique would unduly hamper our system of jurisprudence in adjusting to the changing times. The late Dean Prosser expressed this view as follows:
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> These are shifting sands, and no fit foundation. There is a duty if the court says there is a duty; the law, like the Constitution, is what we make it. Duty is only a word with which we state our conclusion that there is or is not to be liability; it necessarily begs the essential question. When we find a duty, breach and damage, everything has been said. The word serves a useful purpose in directing attention to the obligation to be imposed upon the defendant, rather than the causal sequence of events; beyond that it serves none. In the decision whether or not there is a duty, many factors interplay: The hand of history, our ideas of morals and justice, the convenience of administration of the rule, and our social ideas as to where the loss should fall. In the end the court will decide whether there is a duty on the basis of the mores of the community, "always keeping in mind the fact that we endeavor to make a rule in each case that will be practical and in keeping with the general understanding of mankind."

Althaus, 562 Pa. at 552-53, 756 A.2d at 1169 (quoting *Sinn*, 486 Pa. at 164, 404 A.2d at 681 (citations omitted)).

[12] A proper resolution of the duty question may depend upon a myriad

Thus, it can be seen that Pennsylvania's traditional construct for determining duty entails a much more precise inquiry than merely repositing such obligations within the rubric of "negligence laws," or "general healthcare regulation." *Pappas I*, 555 Pa. at 349, 352, 724 A.2d at 892, 894. Once fairly undertaken (and to the extent that the third-party plaintiff is asserting a duty on U.S. Healthcare's part in favor of the original plaintiff consistent with our joinder rules), the pertinent analysis should inform the conflict preemption determination (assuming, again, that something more is required than the mere identification of whether a fiduciary act was involved), with the final resolution to the question depending ultimately upon the manner in which the jury is charged on the subject.

It cannot escape notice that the above analysis, when applied to managed care organizations, necessarily entails precisely the sorts of judgments about socially acceptable medical risks that the United States Supreme Court declined to make in *Pegram II* for purposes of ERISA fiduciary analysis. *See Pegram II*, 530 U.S. at 221-22, 120 S.Ct. at 2150. It is difficult to disagree with the Supreme Court's assessment that the legislative branch presents a superior forum for the resolution of such duties, particularly in an arena as significant as managed

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of factors, including the nature and incentive structure of the managed care entity; the applicable legislative and regulatory requirements for services; the specific promises made at the outset of the contractual relationship; and whether and to what extent the policy and incentive structure operate to deprive patients of the option of making an informed decision as to whether to fund services themselves. In making such inquiries, our trial courts would be advised to consider the scope of the civil enforcement provisions of ERISA, 29 U.S.C. § 1132, since, in appropriate cases, transgression into this area may lead to the assertion of federal jurisdiction under the doctrine of complete preemption. *Compare generally Corporate Health*, 215 F.3d at 537, *with Bauman*, 193 F.3d at 161-62.

care;[13] nevertheless, where scant guidance is presented to courts of general redress, they remain charged with the obligation to address claims according to established paradigms.[14] This is particularly the case in the health care arena, since clearly states have a fundamental interest in ensuring quality of care, and it is therefore appropriate for them to implement measures to assure a degree of accountability on the part of managed care organizations. However, given a legislatively sanctioned system which allows for the rationing of treatment, the interest should be balanced against the purpose of managed care organizations to avoid effectively eliminating the infrastructure designed to enhance accessibility to medical resources.[15]

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[13] In fashioning a legislative solution, Congress could also consider the existing disparity between the treatment of claims against managed care organizations providing services to ERISA plans and those that do not. *See generally* Karen A. Jordan, *Coverage Denials in ERISA Plans: Assessing The Federal Legislative Solution,* 65 MO.L.REV. 405, 406-07 (Spr.2000).

[14] In Pennsylvania, the process of development and refinement of applicable duties as a matter of common law may be slow and cumbersome. Our trial courts, as courts of general jurisdiction, are responsible for the determination in the first instance, and cases filter through the intermediate appellate courts, with review being granted by this Court on a discretionary basis, such that the opportunity is provided for careful, informed developments. To the extent that departures from traditional forms are sanctioned, this may occur incrementally, as they will occur in the context of specific cases, rather than in the broader spectrum of the legislative process.

[15] Whether existing managed care organizations are effective in this regard is subject to differing interpretations. What is important here, however, is that Congress at least believed that there was a sufficient potential benefit to warrant express statutory authorization, *see generally Pegram II*, 530 U.S. at 232-35, 120 S.Ct. at 2156-57, and the central role which managed care occupies as a service provider to ERISA plan administration.

Contrary to the majority's footnote 7, I make no suggestion that this Court should presently articulate the duty or standard of care applicable to U.S. Healthcare's conduct. Rather, my point is that the Court should refrain at this juncture from directing that the cause of action against U.S. Healthcare must necessarily be assessed according to medical malpractice precepts and,[16] correspondingly, resolving the preemption inquiry on such basis. I fully acknowledge that any development concerning applicable duties would necessarily occur in the first instance at the common pleas level, *see supra* note 14, and would simply not foreclose any additional preemption assessment to the extent that a further consideration of duty would be appropriate in this case.

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[16] In its rebuttal to this dissent, the majority appears to ameliorate this difficulty by noting, "[w]hether the element of duty or the standard of care to which U.S. Healthcare should be held when third party plaintiffs attempt to prove their case differs from the duty or standard of care that Pennsylvania law imposes on non-HMO physicians is an issue that may remain for another day." However, the majority has not altered its textual assertion to the effect that "[U.S. Healthcare's decision] was a mixed eligibility and treatment decision, the adverse consequences of which, if any, are properly redressed ... through state medical malpractice law." In my view, these statements simply are not reconcilable. Moreover, the former statement appears to concede that there may be something left of the preemption inquiry, since it would be exceedingly difficult to determine whether a state-law duty is preempted unless and until the nature of such duty can be discerned.

Thus, in answer to the final characterization provided by the majority in its footnote 7, I am not advocating that "all roads lead to preemption." My concern is, rather, the avoidance of categorical statements regarding preemption until the road which is to be taken (that is, state law duties with which the defendant is being charged) can be identified for purposes of assessing the potential for conflict with the pertinent federal statutes and interests involved.

In summary, I agree with the majority that in the aftermath of *Pegram II* and *Travelers*, state laws having general application and relating to areas traditionally subject to state regulation are more likely to survive preemption challenges. I am not as certain, however, that the Supreme Court would confine the possibility of preemption solely to those cases involving pure eligibility determinations, and I believe that the reasoning of *Pegram II* contains at least inferential evidence to the contrary. In my view, *Travelers'* alteration in the course of ERISA preemption jurisprudence, which was emphasized by this Court in *Pappas I*, may evidence more than the fact of a stricter preemption construct. It may also demonstrate that the preemption inquiry may not be presently capable of distillation into questions answerable in a simple "yes" and "no" fashion. Rather, in absence of an appropriate legislative solution, the inquiry may have to endure a degree of further evolution in the law, perhaps substantial, at both the state and federal levels, particularly as it applies to an industry which occupies a societal role that touches the citizenry at large and is itself rapidly evolving.

In light of the above, I would modify this Court's original order to be without prejudice to U.S. Healthcare's ability to assert preemption arguments after such time as the trial court devises appropriate jury instructions.

APPENDIX B

Supreme Court of Pennsylvania.

Basile PAPPAS and Theodora Pappas, H/W, Plaintiffs,
v.
David S. ASBEL, D.O., Defendant.
Pennsylvania Hospital Insurance Co. (PHICO) and the Commonwealth of
Pennsylvania Medical Professional Liability Catastrophe Loss Fund (Cat Fund),
Defendants/Appellees,
v.
United States Healthcare Systems of Pennsylvania, Inc.,
Additional Defendant/
Appellant.

Argued April 30, 1997.
Decided Dec. 23, 1998.
Reargument Denied Feb. 12, 1999.

Before FLAHERTY, C.J., and ZAPPALA, CAPPY, CASTILLE, NIGRO, and NEWMAN, JJ.

OPINION OF THE COURT

CAPPY, Justice.

This is an appeal from the order of the Superior Court reversing the trial court's entry of summary judgment in favor of third-party defendant United States Healthcare Systems of Pennsylvania, Inc. ("U.S. Healthcare"). The issue on which this

court granted allocatur is whether the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. 1001, *et seq.*, preempts the state tort law claims brought against U.S. Healthcare. For reasons which differ from those relied upon by the Superior Court, we find that ERISA does not preempt these claims. We therefore affirm the order of the Superior Court.

At 11:00 a.m. on May 21, 1991, Basile Pappas ("Pappas") was admitted to Haverford Community Hospital ("Haverford") through its emergency room complaining of paralysis and numbness in his extremities. At the time of his admission, Pappas was an insured of HMO-PA, a health maintenance organization operated by U.S. Healthcare.

Dr. Stephen Dickter, the emergency room physician, concluded that Pappas was suffering from an epidural abscess which was pressing on Pappas' spinal column. Dr. Dickter consulted with a neurologist and a neurosurgeon; the physicians concurred that Pappas' condition constituted a neurological emergency. Given the circumstances, Dr. Dickter felt that it was in Pappas' best interests to receive treatment at a university hospital.

Dr. Dickter made arrangements to transfer Pappas to Jefferson University Hospital ("Jefferson") for further treatment. At approximately 12:40 p.m. when the ambulance arrived, Dr. Dickter was alerted to the fact that U.S. Healthcare was denying authorization for treatment at Jefferson. Ten minutes later, Dr. Dickter contacted U.S. Healthcare to obtain authorization for the transfer to Jefferson. At 1:15 p.m., U.S. Healthcare responded to Dr. Dickter's inquiry and advised him that authorization for treatment at Jefferson was still being denied, but that Pappas could be transferred to either Hahnemann University ("Hahnemann"), Temple University or Medical College of Pennsylvania ("MCP").

Dr. Dickter immediately contacted Hahnemann. That facility advised Haverford at approximately 2:20 p.m. that it would not have information on its ability to receive Pappas for at least another half hour. MCP was then reached and within minutes it agreed to accept Pappas; Pappas was ultimately transported there at 3:30 p.m. Pappas now suffers from permanent quadriplegia resulting from compression of his spine by the abscess.

Pappas and his wife filed suit against Dr. David Asbel, his primary care physician, and Haverford. They claimed that Dr. Asbel had committed medical malpractice and that Haverford was negligent in causing an inordinate delay in transferring him to a facility equipped and immediately available to handle his neurological emergency.

Haverford then filed a third party complaint against U.S. Healthcare, joining it as a party defendant for its refusal to authorize the transfer of Pappas to a hospital selected by the Haverford physicians. Dr. Asbel also filed a cross-claim against U.S. Healthcare seeking contribution and indemnity.

U.S. Healthcare filed a motion for summary judgment on all of the third party claims, alleging that the third party claims are preempted by § 1144(a) of ERISA.[1] The trial court granted the motion.[2] The Superior Court on appeal, however,

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[1] It is uncontested that U.S Healthcare is an "employee benefits plan" pursuant to ERISA, 29 U.S.C. § 1002(1), and that ERISA therefore applies to this matter.

[2] Approximately one year after the trial court granted summary judgment in U.S. Healthcare's favor, Dr. Asbel and Haverford settled the actions brought against them. They have been substituted in this appeal by their insurers, Pennsylvania Hospital Insurance Co. ("PHICO") and the Commonwealth of Pennsylvania Medical Professional Liability Catastrophic Loss Fund ("CAT Fund").

determined that ERISA did not preempt the state law claims. This court subsequently granted U.S. Healthcare's Petition for Allowance of Appeal in order to determine whether these third party claims fall within the scope of those state actions which are preempted by ERISA.

In reviewing whether a trial court's award of summary judgment was appropriate, we view the record in the light most favorable to the non-moving party, and all doubts as to the existence of a genuine issue of material fact must be resolved against the moving party. *Pennsylvania State University v. County of Centre*, 532 Pa. 142, 144-145, 615 A.2d 303, 304 (1992). Only where there is no genuine issue as to any material fact and it is clear that the moving party is entitled to a judgment as a matter of law will summary judgment be entered. *Skipworth v. Lead Industries Assoc., Inc.*, 547 Pa. 224, 230, 690 A.2d 169, 171 (1997). As the issue presented in this case is one of law, our scope of review is plenary. *See Phillips v. A-BEST Products Co.*, 542 Pa. 124, 130, 665 A.2d 1167, 1170 (1995).

Our analysis begins with a review of the basic principles of preemption law. The Supremacy Clause of the United States Constitution provides that the laws of the federal government "shall be the supreme Law of the Land; ... any Thing in the Constitution or Laws of any state to the Contrary notwithstanding." U.S. Const., art. VI, cl. 2. It is this clause which gives to the United States Congress power to preempt state law.

In determining whether state law is preempted by a federal law, a reviewing court is cautioned that such a review "start[s] with the assumption that the historic police powers of the States [are] not to be superseded by ... Federal Act unless it [is] the clear and manifest purpose of Congress." *Cipollone v. Liggett Group*, 505 U.S. 504, 516, 112 S.Ct. 2608, 2617, 120 L.Ed.2d 407, 422 (1992) (citations omitted). Thus, Congress' intent is the "ultimate touchstone" in this analysis. *Id.*

A state law can be preempted in one of three ways. The first is where the United States Congress enacts a provision expressly preempting state law. *Pacific Gas and Electric Co. v. State Energy Resources Conservation and Development Comm'n,* 461 U.S. 190, 103 S.Ct. 1713, 75 L.Ed.2d 752 (1983). Even where there is no explicit preemption provision, preemption will still be found where Congress has legislated the field so comprehensively that it has implicitly communicated the intent to occupy a given field to the exclusion of state law. *Schneidewind v. ANR Pipeline Co.*, 485 U.S. 293, 299-300, 108 S.Ct. 1145, 1150-51, 99 L.Ed.2d 316, 325 (1988). Finally, a state law will be preempted where a state law actually conflicts with federal law. *Id. See also Cellucci v. General Motors Corp.*, 550 Pa. 407, 706 A.2d 806, (1998).

It is this first method of preemption which is at issue in this matter. The express preemption provision in question states that "the provisions of this subchapter ... shall supersede any and all State laws[3] insofar as they may now or hereafter relate to any employee benefit plan...." 29 U.S.C. § 1144(a).

None of the parties in this matter dispute that the United States Supreme Court has yet to speak directly to the issue of whether negligence claims against a health maintenance organization "relate to" an ERISA plan. U.S. Healthcare, however, cites to several United States Supreme Court cases from the 1980's and early 1990's as support for its contention that these claims should be preempted by ERISA.

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[3] "State law" was defined by Congress as including "all laws, decisions, rule, regulations, or other State action having the effect of law." 29 U.S.C. § 1144(c)(1). It is uncontested that a decision handed down by a state court, which would enter the common law of that state, is a "State law" as defined by ERISA.

U.S. Healthcare is indeed accurate in its claim that the Supreme Court had given the ERISA preemption provision an almost breathtaking scope in the 1980's and early 1990's. The Court stated that the preemption provisions were "deliberately expansive". *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 46, 107 S.Ct. 1549, 1552, 95 L.Ed.2d 39, 49 (1987). The Court at that time held the opinion that "[t]he breadth of [§ 1144(a)'s] preemptive reach is apparent from that section's language." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96, 103 S.Ct. 2890, 2899-2900, 77 L.Ed.2d 490, 501 (1983). It declared that the words of the preemption provision were to be given their "broad common-sense meaning, such that a state law 'relate[s] to' a benefit plan in the normal sense of the phrase, if it has a connection with or reference to such a plan." *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739, 105 S.Ct. 2380, 2388, 85 L.Ed.2d 728, 740 (1985) (citations omitted). In the vast majority of cases concerning ERISA preemption addressed by the Court during this period, it was found that the state laws being reviewed had some "connection with" or "reference to" the ERISA plan. Although the Court did concede that the ERISA preemption provision "perhaps [is] not the model of legislative drafting" that the Court would hope for, *Pilot Life*, 481 U.S. at 46, 107 S.Ct. at 1552, 95 L.Ed.2d at 47, the Court in the 1980's and early 1990's did not admit to any possibility that the plain meaning of the words of the preemption provision could not be given effect.

The Court noticeably changed tack in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 115 S.Ct. 1671, 131 L.Ed.2d 695 (1995). In *Travelers*, the unanimous Court determined that a New York statute which required hospitals to collect surcharges from patients covered by all commercial insurers other than Blue Cross/Blue Shield was not preempted by ERISA. After years of striving to make sense of the plain language of the preemption provision, the Court frankly admitted that the text is "unhelpful". *Id.* at 656, 115 S.Ct. at 1677, 131 L.Ed.2d at 705. The Court

recognized that "[i]f 'relate to' were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course, for '[r]eally, universally, relations stop nowhere.' " *Id.* at 655, 115 S.Ct. at 1677, 131 L.Ed.2d at 705 (citations omitted). The Court reasoned that the language of the preemption provision is so extensive that if the Court were to look merely to the bare language of the provision, the provision would for all intents and purposes be without limit--an intent which the Court would not ascribe to Congress. *Id.* The Court concluded that "we have to recognize that our prior attempt to construe the phrase 'relate to' does not give us much help in drawing the line here," and that it "must go beyond the unhelpful text and the frustrating difficulty of defining its key term, and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." *Id.* at 656, 115 S.Ct. at 1677, 131 L.Ed.2d at 705.

The Court determined that the "basic thrust of the preemption provision ... was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans." *Id.* at 657, 115 S.Ct. at 1677-1678, 131 L.Ed.2d at 706. It recognized fairly significant bounds on the preemption provision when it stated that "[p]re-emption does not occur ... if the state law has only a tenuous, remote, or peripheral connection with covered plans, as in the cases with many laws of general applicability. " *Id.* at 661, 115 S.Ct. at 1680, 131 L.Ed.2d at 708-709 (citation omitted). The Court also cautioned that "nothing in the language of [ERISA] or in the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern." *Id.* at 661, 115 S.Ct. at 1680, 131 L.Ed.2d at 709 (citations omitted).

The cases following *Travelers* have continued this trend. In *California Division of Labor Standards Enforcement v. Dillingham Construction, NA., Inc.*, 519 U.S. 316, 117 S.Ct. 832,

136 L.Ed.2d 791 (1997), the majority relied upon *Travelers* to find that a California prevailing wage law was not preempted by ERISA. It is in the concurring opinion authored by Mr. Justice Scalia, however, that we find the most cogent recognition that the law of ERISA preemption had, in effect, been changed by *Travelers*. Mr. Justice Scalia opined that the cases from the 1980's and early 1990's, which were premised upon the now rejected notion that the plain language of the ERISA preemption provision could be given effect, were superannuated. He reproached the Court for not forthrightly acknowledging that the holdings of these older cases "have in effect been abandoned." *Id.* at 335, 117 S.Ct. at 843, 136 L.Ed. at 806 (Scalia, J., concurring). He believed that since *Travelers* recognized that literal interpretation of the provision "relate to" was unworkable, then earlier cases which concluded that the plain language of the preemption provision justified findings that the provision had "broad scope" and was "conspicuous for its breadth" were simply no longer good law. *Id.*

This new position on ERISA preemption was reiterated in *De Buono v. NYSA- ILA Medical and Clinical Services Fund*, 520 U.S. 806, 117 S.Ct. 1747, 138 L.Ed.2d 21 (1997). The question presented in *De Buono* was whether a New York gross receipts tax could be applied to hospitals operated by ERISA plans. The Court again stated that the language "relates to" was unhelpful and that it must instead explore Congress' intent in enacting ERISA in order to determine if a state law would indeed fall within ERISA's preemptive scope. *Id.* at 812, 117 S.Ct. at 1751, 138 L.Ed.2d at 29. The Court determined that the gross receipts tax was not preempted by ERISA because it was "one of myriad state laws of general applicability that impose (sic) some burdens on the administration of ERISA plans but nevertheless do not 'relate to' them within the meaning of the governing statute.... Any state tax, or other law, that increases the cost of providing benefits to covered employees will have some effect on the administration of ERISA plans, but that simply cannot mean that every state law with such an effect is

pre-empted by the federal statute." *Id.* at 815-816, 117 S.Ct. at 1752-1753, 138 L.Ed.2d at 30-31 (citations omitted).[4]

Thus, although U.S. Healthcare is correct when it states that U.S. Supreme Court decisions from the 1980's and early 1990's support its position that the preemption provision is to be read broadly, *Travelers* and its progeny have thrown the expansive holdings of those earlier cases into question.[5] We thus believe that it would be improper to adopt U.S. Healthcare's position that we must reflexively interpret the preemption provision in the broadest possible manner. Instead, we believe that the proper course of action is to follow the reasoning

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[4] We note that another case concerning ERISA preemption was decided the same day *De Buono* was handed down. *Boggs v. Boggs*, 521 U.S. 1138, 118 S.Ct. 9, 138 L.Ed.2d 1043 (1997). *Boggs*, however, does not lend anything to the analysis of the matter *sub judice*. In *Boggs*, the Court determined that Louisiana common law was preempted as it was in direct conflict with §§ 1055 and 1056 of ERISA, substantive provisions which limit the alienability of pension plan benefits from a surviving spouse. In this matter, it is not asserted that a claim of negligence lodged against an HMO is in conflict with any substantive provision of ERISA.

[5] U.S. Healthcare also cites to a number of circuit court decisions which have held that claims against HMOs are preempted by ERISA. *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321 (5th Cir.1992); *Tolton v. American Biodyne, Inc.*, 48 F.3d 937 (6th Cir.1995); *Kuhl v. Lincoln Nat'l Health Plan of Kansas City, Inc.*, 999 F.2d 298 (8th. Cir.1993); *Spain v. Aetna Life Ins. Co.*, 11 F.3d 129 (9th Cir.1993); *Cannon v. Group Health Service of Oklahoma, Inc.*, 77 F.3d 1270 (10th Cir.1996). Yet, the bulk of these cases were handed down prior to *Travelers*. The only one of these cases which was decided subsequent to *Travelers*--*Cannon*--fails even to mention *Travelers*. Since we find the recent trend of the Supreme Court to be so compelling, it would be inappropriate for us to utilize the reasoning of these courts of appeal cases as they fail to discuss the *Travelers* line of decisions.

contained within the *Travelers* line of cases, even though we recognize that the Court's earlier cases have not been expressly overruled.

Based upon our interpretation of the *Travelers* line of cases, we conclude that negligence claims against a health maintenance organization do not "relate to" an ERISA plan. As noted by *Travelers*, Congress did not intend to preempt state laws which govern the provision of safe medical care. *Travelers*, 514 U.S. at 661, 115 S.Ct. at 1680, 131 L.Ed.2d at 709. Claims that an HMO was negligent when it provided contractually-guaranteed medical benefits in such a dilatory fashion that the patient was injured indisputably are intertwined with the provision of safe medical care. We believe that it would be highly questionable for us to find that these claims were preempted when the United States Supreme Court has stated that there was no intent on the part of Congress to preempt state laws concerning the regulation of the provision of safe medical care.[6]

Furthermore, we believe that negligence laws have "only a tenuous, remote, or peripheral connection with [ERISA]

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[6] The Superior Court below, in reasoning that ERISA does not preempt negligence claims lodged against HMOs, stated that "[c]onsiderations of cost containment of the type which drive the decision making process in HMO's did not exist for employee welfare plans when ERISA was enacted." *Pappas v. Asbel*, 450 Pa.Super. 162, 171, 675 A.2d 711, 716 (1996). The Superior Court concluded that Congress could not have intended to preempt that which it did not know would come into existence. We find that we are unable to adopt this reasoning that the modern day HMO was unforeseen by Congress when it drafted ERISA. Just one year preceding the enactment of ERISA, Congress enacted the Health Maintenance Organization Act of 1973, 42 U.S.C. § 300e *et seq.* The HMOs described in that act are too similar to a contemporary HMO for us to conclude that Congress, when crafting ERISA, was ignorant of the cost containment procedures utilized by HMOs.

covered plans, as in the cases with many laws of general applicability," *Travelers*, 514 U.S. at 661, 115 S.Ct. at 1680, 131 L.Ed.2d at 708-709, and therefore are not preempted. We acknowledge that by allowing negligence claims, there will be a financial impact on HMOs. Yet, that is not enough to countermand the conclusion that these claims are not preempted. As noted by the *De Buono* Court, an incidental increase in the costs imposed on an ERISA plan will not mandate a finding of preemption. *De Buono*, 520 U.S. at 815-816, 117 S.Ct. at 1752-1753, 138 L.Ed.2d at 30-31.

For the foregoing reasons, we conclude that ERISA does not preempt the claims in question. The order of the Superior Court is affirmed.[7]

Justice NIGRO files a concurring opinion.

NIGRO, Justice, concurring.

I concur in the result reached by the Majority. I agree that the *Traveler*'s line of cases in the United States Supreme Court supports the proposition that issues raising ERISA preemption are to be narrowly construed. I write separately, however, to explain why the present negligence claim against U.S. Healthcare falls outside that narrow construction and is therefore not preempted. Here, the defendant physician and

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[7] We also note that U.S. Healthcare puts great effort into arguing that it is not the negligent party here, and that Haverford and the physicians involved are solely responsible for the Pappas' injuries. U.S. Healthcare may ultimately be vindicated on these claims, but this is not the proper stage for these arguments. The issue with which we are concerned in this case is whether the claims against U.S. Healthcare are preempted; we have determined that they are not. It is now left for the fact-finder to determine if U.S. Healthcare's defenses to the negligence claims are valid.

hospital brought U.S. Healthcare into the action claiming that it was U.S. Healthcare's refusal to authorize a medically necessary transfer which caused plaintiff's ultimate injury. Based upon the facts set forth in the Majority Opinion, I find that U.S. Healthcare's actions constituted, in effect, an individual medical decision or judgment as opposed to a decision affecting the administration of an employee benefit plan. Here, the parties are merely attempting to assert their already existing rights under the generally applicable state law of agency and tort. *See Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 358 (3d Cir.1995), *cert. denied.*, 516 U.S. 1009, 116 S.Ct. 564 (1995).

The federal courts have addressed issues similar to the present matter. *Independence HMO, Inc. v. Smith*, 733 F.Supp. 983 (E.D.Pa.1990), presented an analogous situation as the injured party sued her HMO after receiving negligent medical treatment from a physician on its approved list. The *Smith* court, in finding the plaintiff's action was not preempted, stated that such a state tort action did not " 'impact upon' an employee benefit plan or 'affect the Congressional scheme contained in [ERISA]'." *Id.* at 988.

Moreover, as the Third Circuit recently explained, "patients enjoy the right to be free from medical malpractice regardless of whether or not their medical care is provided through an ERISA plan." *Dukes*, 57 F.3d at 358. *Dukes* explains that ERISA is principally concerned with the various mechanisms and institutions involved in the funding and payment of plan benefits and was intended to provide each participant with a remedy in the event that promises made by the plan were not kept. *Id.* at 357. *Dukes* distinguishes between claims that the "quantum" of benefits promised were not provided, which *is* controlled by ERISA, and the "quality" of the benefits actually received, which is *not* controlled by ERISA. *Id.* *Dukes* concluded that "[q]uality control of benefits, such as the health care benefits provided here, is a field traditionally occupied by state regulation and we interpret the silence of

Congress as reflecting an intent that it remain such." *Id.* I would adopt the rationale of the *Smith* and *Dukes* decisions and find that the negligence action against U.S. Healthcare is not preempted.

Therefore, I believe the overall purpose for the enactment of ERISA, as well as subsequent case law, would indicate that the negligence claim against U.S. Healthcare does not fall under the aegis of the preemption clause. It is for these reasons that I find state negligence laws have "only a tenuous, remote, or peripheral connection with [ERISA] covered plans...." *New York State Conference of Blue Cross & Blue Shield Plans, et al. v. Travelers Insurance Company et al.*, 514 U.S. 645, 661, 115 S.Ct. 1671, 1679, 131 L.Ed.2d 695, ---- (1995) (citing *District of Columbia v. Greater Washington Board of Trade*, 506 U.S. 125, 129 n. 1, 113 S.Ct. 580, 583, n. 1, 121 L.Ed.2d 513 (1992)).

APPENDIX C

Superior Court of Pennsylvania.

Basile PAPPAS and Theodora Pappas, H/W
v.
David S. ASBEL, D.O. and Pennsylvania Hospital Insurance Co. (PHICO).
The COMMONWEALTH OF PENNSYLVANIA MEDICAL PROFESSIONAL LIABILITY CATASTROPHE LOSS FUND (CAT FUND)
v.
UNITED STATES HEALTHCARE SYSTEMS OF PENNSYLVANIA, INC.
Appeal of PHICO INSURANCE COMPANY and The Pennsylvania Medical Professional Liability Catastrophe Loss Fund.

Argued Jan. 9, 1996.
Filed March 15, 1996.
Reargument Denied May 23, 1996.

Before KELLY and HOFFMAN, JJ. and MONTEMURO, Senior Judge.*

MONTEMURO, Senior Judge:

This appeal lies from an order granting summary judgment to appellee, United States Healthcare, Inc. (USHC), on the basis that the third party complaint of appellant Haverford Community Hospital is preempted by Section 1144(a) of the

* Retired Justice assigned to Superior Court.

Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1001, *et seq.*

On May 20, 1990, Basile Pappas, a subscriber to USHC, an HMO provided through his wife's employment, presented himself at the offices of his primary care physician, Dr. David Asbel, complaining of neck and shoulder pain. The treatment administered was an intramuscular injection of steroids. By the next day, Mr. Pappas' condition had deteriorated significantly, and, unable to walk, complaining of numbness in his arms, chest, abdomen and legs, he was transported to appellant Haverford Community Hospital at 11:00 a.m. There, after examination and preliminary testing which revealed an abnormally elevated white blood cell count, Mr. Pappas was preliminarily diagnosed as suffering from a cervical epidural abscess which was compressing his spinal cord. Dr. Dickter, the emergency room physician responsible for Mr. Pappas' care, determined that the case constituted a neurologic emergency requiring further, immediate diagnosis and treatment at a university hospital with more extensive facilities than those available at Haverford.

After telephone consultation with Dr. Asbel, as well as Haverford's staff neurologist and neurosurgeon, arrangements were made by 12:30 to transfer Mr. Pappas to Thomas Jefferson University Hospital, which, possessing a spinal cord trauma unit, was able to assure Mr. Pappas' immediate admission. However, at 12:40 the ambulance service which was to transport Mr. Pappas informed the physicians at Haverford that as Jefferson was not an approved facility, authorization for Mr. Pappas' removal there was not forthcoming from USHC. At 12:50, Dr. Dickter telephoned USHC in an attempt to obtain authorization, and to do so quickly in view of the nature of the emergency. At 1:05, Dr. Dickter was informed by USHC that, after review, authorization for treatment at Jefferson was still being denied, but that Mr. Pappas could be removed to Hahnemann University, Temple University or Medical College of Pennsylvania. The

USHC physician[1] who had made this decision refused to speak directly to Dr. Dickter, despite several requests that he do so, and after USHC was informed that Mr. Pappas' condition could worsen or become permanent. Rather, USHC's position was communicated through administrative personnel. Since Dr. Asbel expressed a preference for Hahnemann, that facility was contacted immediately but advised Haverford at about 2:20 p.m. that it would not have information on its ability to receive Mr. Pappas for at least another half hour. MCP was then reached and within minutes notified the physicians that it could accept Mr. Pappas, who was ultimately transported there at about 3:30 p.m. Mr. Pappas now suffers from permanent quadriplegia resulting from compression of his spine by the abscess.

Mr. Pappas brought suit against Asbel and Haverford, claiming various forms of malpractice as to the former, and as to the latter, negligence in causing an inordinate delay in transferring him to a facility equipped and immediately able to address the neurological emergency, thus exacerbating the compression of the spine which caused his quadriplegia. Haverford then filed a third party complaint against USHC, joining it as a party defendant for its refusal to authorize the transfer of Mr. Pappas to the hospital selected by the Haverford physicians, and adopting the negligence claims lodged against it in the original complaint. In his answer and new matter, Dr. Asbel filed a cross claim against USHC seeking contribution and/or indemnity. After filing both Answer and New Matter and Preliminary Objections, which failed to mention preemption, USHC successfully filed a motion for summary judgment alleging that the third party complaint should be dismissed, having been preempted by § 1144(a) of ERISA. This appeal

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[1] The record does not reveal the field of specialization of this physician, a Dr. Liebowitz [*sic*].

followed,[2] presenting the question of whether ERISA was correctly determined to preempt Haverford's claim, characterized by appellant as a state law claim unrelated to ERISA or employee benefits, against USHC.[3]

In reviewing a grant of summary judgment we must determine whether, in view of the pleadings, depositions, answers to interrogatories, admissions on file, together with any affidavits, any genuine issue of material fact exists in the case, and, if not, whether the moving party is entitled to judgment as a matter of law. Moreover, the moving party's right to such a judgment must be clear and free from doubt. *Musser v. Vilsmeier Auction Co., Inc.*, 522 Pa. 367, 562 A.2d 279 (1989); Pa.R.C.P. 1035.

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[2] Mr. Pappas' claims against Dr. Asbel and Haverford were settled by agreement of the parties, and Haverford's interests vis a vis USHC are now represented by the Pennsylvania Hospital Insurance Company and the Commonwealth of Pennsylvania Medical Professional Catastrophic Loss Fund.

[3] There is no question that USHC is an employee benefits plan as defined by ERISA, 29 USCS § 1002(1):

> The terms "employee welfare benefit plan" and welfare plan mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund or program was established or maintained for the purpose of providing for its participants or beneficiaries, through the purchase of insurance or otherwise, (A) medical surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefits described in section 3023(c) of the Labor Management Relations Act, 1947 [29 USCS § 186(c)] (other than pensions on retirement or death, and insurance to provide such pensions)

29 U.S.C. § 1144(a) reads in pertinent part as follows:

> Except as provided in subsection (b) of this section, the provisions of this title ... shall supersede any and all State laws *insofar as they* may now or hereafter *relate to* any employee benefit plan ... (emphasis added).

It may, without fear of contradiction, be asserted that the Supremacy Clause, United States Constitution, Art. VI, expressly or by implication commands preemption of a state law where such law conflicts with federal law. *Pacific Gas and Electric Co. v. State Energy Resources Conservation and Development Commission*, 461 U.S. 190, 103 S.Ct. 1713, 75 L.Ed.2d 752 (1983). It is also well settled that ERISA's supersession provision is vast in its application. *Ingersoll-Rand v. McClendon,* 498 U.S. 133, 111 S.Ct. 478, 112 L.Ed.2d 474 (1990). However, the question still remains as to the precise reach of the phrase "insofar as they ... relate to ..." In *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 103 S.Ct. 2890, 77 L.Ed.2d 490 (1983), the United States Supreme Court held that "[a] law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." *Id.* at 97; 103 S.Ct. at 2900. The trial court in this matter found that the allegations in Haverford's third party complaint all "f[e]ll within the rubric of administration of an employee benefit plan" because they concerned specific actions taken by USHC, namely its refusal to approve Mr. Pappas' transfer to a facility where the care he needed was available immediately as the emergent nature of his condition required.

Because the limitations supplied by the cases attempting to define "relate to" are necessarily vague, the district and circuit courts which have considered the matter of HMO involvement are split on the precise extent of ERISA's reach. A number of federal court cases impose preemption on efforts to hold an HMO liable for injuries resulting from certain of its decisions on the basis that any attempt to seek redress constitutes an attack on

the administration of the HMO, the position adopted by the trial court herein, and thus imposes a restriction such as the Act seeks to avoid. *See, e.g., Kuhl v. Lincoln National Health Plan*, 999 F.2d 298 (8th Cir.1993), *cert. denied,* 510 U.S. 1045, 114 S.Ct. 694, 126 L.Ed.2d 661 (1994) (claim against HMO for denying surgical precertification preempted by ERISA); *Corcoran v. United HealthCare, Inc.*, 965 F.2d 1321 (1992), *cert. denied,* 506 U.S. 1033, 113 S.Ct. 812, 121 L.Ed.2d 684 (1992) (claims against HMO for failure to provide hospitalization to expectant mother resulting in death of unborn child). All of these cases have in common the reasoning that the state law claims involved necessarily "relate to" administration of the plans in question and are therefore preempted under the broad sweep of § 1144(a).

The United States Supreme Court, however, albeit in dealing with factual settings which differ from the sorts of claims involved in these cases, has refined the "relate to" language, thus truncating it to some extent. In *Mackey v. Lanier Collection Agency and Service,* 486 U.S. 825, 108 S.Ct. 2182, 100 L.Ed.2d 836 (1988), attendant upon a finding that a state garnishment action against participants in an ERISA plan providing vacation and holiday benefits was not preempted, the Court noted:

> ERISA plans may be sued in a second type of civil action as well. These cases--lawsuits against ERISA plans for run of the mill state law claims such as unpaid rent, failure to pay creditors, or even torts committed by an ERISA plan--are relatively commonplace. Petitioners and the United States (appearing here as amicus curiae) concede that these suits, although obviously affecting and involving ERISA plans and their trustees, are not preempted by ERISA § 514(a).

Id. at 833, 108 S.Ct. at 2187 (emphasis added).

In the recent case of *New York Blue Cross v. Travelers Insurance Co.*, 514 U.S. 645, 115 S.Ct. 1671, 131 L.Ed.2d 695 (1995), the Court has indicated that § 1144(a) may well be further limited. There, the Court examined a New York statute which requires hospitals to collect surcharges from patients covered by designated commercial insurers and imposes a surcharge on certain HMO's, but exempts from the surcharges those patients insured by a Blue Cross/Blue Shield plan. In holding that the surcharge provisions do not "relate to" employee benefit plans, the Court noted that the language of ERISA is so expansive as to be, for all practical purposes, infinite: unless read in conjunction with the structure and purpose of the statute as a whole, the words of limitation, "insofar as they ... relate to ...," are not limiting at all, and Congress' intention must be interpreted as a sham. *Id.* at ----, 115 S.Ct. at 1677. Rather, the Court determined to "go beyond the unhelpful text and the frustrating difficulty of defining its key term, and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." *Id.* The Court then observed that "[t]he basic thrust of the preemption clause ... was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans," *id.* at ----, 115 S.Ct. at1677-78, that is, to protect it from conflicting directives. However, the Court went on to note that "nothing in the language of the Act or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern." *Id.* at ----, 115 S.Ct. at 1680. The Court extrapolated from its findings that "a law operating as an indirect source of merely economic influence on administrative decisions ... should not suffice to trigger preemption." *Id.*

This last is especially pertinent to the question presented here despite the variance in context. What is at issue is a negligence claim identical to the one lodged against Haverford by Mr. Pappas in the underlying complaint. The type of recovery sought is based on negligence attributable to the delay

occasioned by a cost containment protocol set by a for-profit organization, and which is aimed at conserving and increasing its profits, an intention diametrically opposed to ERISA's general purpose of protecting the rights of a plan's beneficiaries. Decisions such as that made by USHC concerning where Mr. Pappas might receive treatment are propelled by dollar savings, not the protection of worker's rights, in this case the right to the most effective medical care, which was the original focus of ERISA. In fact, the argument has never been advanced that the decision to withhold approval for transfer to Jefferson was at all related to medical considerations.

Considerations of cost containment of the type which drive the decision making process in HMO's did not exist for employee welfare plans when ERISA was enacted. It cannot therefore be argued that the type of recovery sought here was deliberately excluded from the Congressional schema in order to protect ERISA plans from conflicting directives which would, in attempting to control expenses, affect medical judgments. A tort claim such as that advanced here is, in fact, "an indirect source of merely economic influence on administrative decisions." *Id.* To find that such claims are preempted because they may interfere with what is in essence a business decision made in the financial interests of a commercial entity is inconsistent with the intention of ERISA and should not "suffice to trigger preemption." *Id.*

This conclusion is consistent with cases in which courts found that a particular state claim is not preempted, based on the rationale that the state law involved affects ERISA in an indirect manner, or is so tenuous or remote as to obviate the necessity for preemption. *Greenblatt v. Budd*, 666 F.Supp. 735, 741 (E.D.Pa.1987) (common law action for misrepresentation by employee whose pension benefits were denied after company merger not preempted.) To make such a determination, it is the state statute which must be examined, and an assessment made of whether the action represents exercise of a classically

important state function preempted neither expressly or impliedly by ERISA. *Id.* Contrast, *Memorial Hospital System v. Northbrook Life Insurance Company*, 904 F.2d 236 (5th Cir.1009) (action for deceptive trade practices by health care provider against plan trustees not preempted, because enforcing allocation of risks between commercial entities conducting business in a state is a classically important state interest, and because health care provider is not a party to plan.) General health care regulation is, as has already been noted, traditionally an area of state concern. *New York Blue Cross*, supra.

While decisions of the federal district courts and courts of appeal, including those of the Third Circuit, are not binding on Pennsylvania courts, even where a federal question is involved, *Breckline v. Metropolitan Life Insurance Company*, 406 Pa. 573, 578, 178 A.2d 748, 751 (1962), they are both persuasive as to federal questions, *Chiropractic Nutritional Associates, Inc. v. Empire Blue Cross and Blue Shield, Inc.*, 447 Pa.Super. 436, 445, 669 A.2d 975, 980 (1995), and those of the Third Circuit are appropriate for this court to follow where the United States Supreme Court has not spoken. *Id.* In *Dukes v. US Healthcare, Inc.*, 57 F.3d 350, 357 (3d Cir.1995) (claims for direct negligence of HMO remanded to state court for determination of whether preemption was mandated),[4] the Third Circuit recognized that "Quality control of benefits ... is a field traditionally occupied by state regulation, and we interpret the silence of Congress as reflecting an intent that it remains so." *See also, Independence HMO, Inc. v. Smith*, 733 F.Supp. 983

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[4] Appellee argues that this case is inapposite as it concerned only the issue of whether it was proper to remove the case to federal court based on ERISA's preemption provision--no decision was reached as to whether this provision actually applied. However, as appellant points out, the court was not able to articulate any plan-created right that was threatened by the plaintiffs' state law negligence claims. Had it been able to do so the decision as to preemption would not even be regarded as equivocal; the claim would have been dismissed.

(1990) (state court action for medical malpractice under ostensible agency theory not preempted by ERISA).

In *Krashna v. Oliver Realty Inc.*, 895 F.2d 111 (3d Cir.1990), albeit in another context, the Court of Appeals for the Third Circuit stated that in order to show that what purports to be a state law claim is completely preempted by federal statute, two factors must be shown:

> First, "the statute relied upon by the defendant as preemptive [must] contain [ ] civil enforcement provisions within the scope of which the plaintiff's state claim falls." ... The federal statute must subsume the interest vindicated by the state law, not the remedy provided.... Second, there must be "a clear indication of a Congressional intention to permit removal despite the plaintiff's exclusive reliance on state law."

Id. at 114, quoting *Railway Labor Executives Ass'n. v. Pittsburgh & L.E. R.R.*, 858 F.2d 936, 942 (3d Cir.1988). *See also, Plucinski v. I.A.M. National Pension Fund, et al*, 875 F.2d 1052 (3d Cir.1989) (In accountancy malpractice case brought by a plan, the conclusion was reached that ERISA does not generally preempt state professional malpractice claims.)

ERISA's civil enforcement provision, § 1132(a)(1)(B), permits beneficiaries of employee welfare plans to "recover benefits due ... under the terms of the plan," "to enforce ... rights under the terms of the plan or to clarify rights to future benefits under the terms of the plan." As the *Dukes* court observes,

> Inherent in the phrases "rights under the terms of the plan" and "benefits due ... under the terms of [the] plan" is the notion that plan participants and beneficiaries will [by means of litigating tort claims] receive something to which they would not otherwise be entitled. But patients enjoy the right to be free from medical

malpractice regardless of whether or not their medical care is provided through an ERISA plan. *Id.* at 358.

This court has ruled that negligence claims are not preempted by ERISA, as they are not "related to" it. *See, McClellan v. Health Maintenance Organization of Pennsylvania*, 413 Pa.Super. 128, 604 A.2d 1053, *appeal denied,* 532 Pa. 664, 616 A.2d 985 (1992) (suit based on liability of HMO for negligence of agent/physician and on intentional misrepresentation or fraud by HMO itself); *DeGenova v. Ansel,* 382 Pa.Super. 213, 555 A.2d 147 (1988) (suit based on vicarious liability of HMO for the negligence of its agent/physician). Nor are these claims covered by ERISA's civil enforcement provisions. The *DeGenova* court specifically found that the "appellants were not seeking ERISA benefits or claiming improper distribution or administration of ERISA benefits," *Id.* at 219, 555 A.2d at 150, and thus preemption did not apply.

The negligence claims at issue here too have, in fact, no connection to the benefit scheme which Congress sought to protect by preempting laws tending to produce conflicting systemic demands; ERISA is in no way implicated by the claim that USHC negligently caused Mr. Pappas' injuries by its delay in authorizing his transfer. Appellants do not seek benefits denied, because Mr. Pappas was transferred to a hospital capable of supplying the needed services; they do not seek to challenge the administration of the Plan, again because there is no complaint that USHC did not perform its duties. Rather, the argument is that USHC performed its duties in a negligent manner given the exigent nature of the emergency. Finally, if the original complaint had claimed that USHC was vicariously liable because of the negligence of its contracting agents, Dr. Asbel and Haverford, in securing Mr. Pappas' transfer, there would be no question under *McClellan* and *DeGenova* that the claim would withstand preemption.

As the *Corcoran* court points out, to conclude that the preemption of all other claims was incorporated into Congress' intent in enacting ERISA necessarily assigns to Congress the concomitant intent to deprive plaintiffs injured by such negligence of any remedy, state or federal, for serious errors perpetrated by HMO's. However, the Supreme Court of the United States, in analyzing the application of preemption clauses in other statutes, found it "difficult to believe that Congress would, without comment, remove all judicial recourse for those injured by illegal conduct." *Silkwood v. Kerr-McGee Corporation,* 464 U.S. 238, 251, 104 S.Ct. 615, 623, 78 L.Ed.2d 443 (1984) (Award of punitive damages arising out of escape of plutonium from federally licensed nuclear facility not preempted by Atomic Energy Act). *See also, United Construction Workers v. Laburnum Construction Corporation*, 347 U.S. 656, 74 S.Ct. 833, 98 L.Ed. 1025 (1954).

We, too, do not believe that Congress can have intended, prior even to invention of the cost containment system which inheres in USHC's review process, to foreclose recovery to plan beneficiaries injured by negligent medical decisions. We therefore conclude that the negligence claims against appellee are not preempted by ERISA.

The question then becomes what, if any, impact the procedural posture of this case has on the implementation of the preemption provision. The trial court concedes that the "no relation" theory may be a valid one, but concludes that because Haverford Hospital and not Mr. Pappas joined USHC as a party defendant, no theory of recovery which would otherwise be available could apply. Pa.R.C.P. 2255(d) dispenses with such a distinction:

> The plaintiff shall recover from an additional defendant found liable to him alone or jointly with the defendant as though such defendant had been joined as a defendant

> and duly served and the initial pleading of the plaintiff had averred such liability.

See also, Solomon v. Cedar Acres East, Inc., 455 Pa. 496, 317 A.2d 283 (1974).

The effect of a third party complaint joining an additional defendant is thus to make the additional defendant "immediately subject to the plaintiff's claim in every respect and with the same force and effect as if the additional defendant had been originally named as the defendant" in the plaintiff's complaint. *3 Standard Pennsylvania Practice 2d* (1994), § 14:359. The character of the claim does not alter with the procedure used to present it.

Accordingly, we reverse the trial court's order granting summary judgment and remand for further proceedings consistent with this Opinion.

APPENDIX D

IN THE COURT OF COMMON PLEAS OF DELAWARE COUNTY, PENNSYLVANIA
CIVIL ACTION – LAW

BASILE PAPPAS and THEDORA PAPPAS, Plaintiffs	:	No. 92-3903
vs.	:	
DAVID S. ASBEL, D.O., and HAVERFORD COMMUNITY HOSPITAL, and UNITED STATES HEALTHCARE SYSTEMS OF PENNSYLVANIA, INC. Defendants	:	

ORDER

KEELER, J. FILED:

AND NOW, this 3rd day of June, 1994, upon consideration of the motion for Summary Judgment filed by United States Healthcare Systems of Pennsylvania, Inc. (USHC), the various responses filed by the other parties and the memoranda submitted, it is hereby ORDERED that USHC's motion for Summary Judgment is GRANTED.

BY THE COURT:

/s/ Charles C. Keeler, J.
CHARLES C. KEELER, J.

IN THE COURT OF COMMON PLEAS OF
DELAWARE COUNTY, PENNSYLVANIA
CIVIL ACTION – LAW

BASILE PAPPAS and THEODORA PAPPAS, his wife	:	No. 92-3903
vs.	:	
DAVID S. ASBEL, D.O., and HAVERFORD COMMUNITY HOSPITAL	:	
vs.	:	
UNITED STATES HEALTHCARE SYSTEMS OF PENNSYLVANIA, INC.	:	

OPINION

KEELER, J. FILED:

I. FACTS

On or around May 20, 1991, the plaintiff, Basile Pappas, presented himself at the offices of Dr. David Asbel, complaining of neck and shoulder pain. Dr. Asbel examined Mr. Pappas and treated him with an intramuscular injection of medication. Despite this treatment, plaintiff alleges that his condition worsened. The following morning his deterioration manifest itself by rendering Mr. Pappas immobile and by causing numbness in his extremities. He was transported via ambulance to the Haverford Community Hospital ("Haverford") on the morning of May 21, 1991. The plaintiffs provided the hospital with information regarding HMO-PA in order to satisfy the hospital of financial responsibility. Both Mr. and Mrs. Pappas

subscribed to HMO-PA through an employees' health benefits plan provided to Mrs. Pappas by her employer, The Charming Shoppes. HMO-PA is owned by additional defendant U.S. Healthcare Systems of Pennsylvania, Inc. ("USHC"). He was admitted at approximately 11:00 a.m. to the hospital's emergency room. Dr. Steven J. Dickter examined Mr. Pappas and ordered a blood study. The analysis revealed an elevated white cell count. These results in conjunction with the patient's subjective complaints and physical ailments led Dr. Dickter to the conclusion that Mr. Pappas was suffering from an epidural abscess which pressed upon Mr. Pappas' spinal column.

Dr. Dickter consulted with Dr. Slater, a neurologist at Haverford who concurred that the situation constituted a neurologic emergency. This determination was also confirmed by a consultation with Dr. Yalon, a Haverford neurosurgeon. Given the circumstances, Dr. Dickter felt it would be in the patient's best interest to receive treatment at a "university" hospital. Dr. Dickter made arrangements to transfer Mr. Pappas to Jefferson University Hospital for further treatment. At approximately 12:40 p.m. when the ambulance arrived, Dr. Dickter was alerted to the fact that Jefferson was not an approved hospital for HMO-PA. Ten minutes later, Dr. Dickter contacted HMO-PA to inquire as to Jefferson's status as an approved facility. Nearly 15 minutes later, HMO-PA responded to Dr. Dickter's inquiry and advised him that Jefferson was not an approved facility, but that the patient could be transferred either Hahnemann, Temple or Medical College of Pennsylvania ("MCP").

Dr. Dickter then telephoned Dr. Asbel and sought his preference concerning the patient's destination. Dr. Asbel expressed a preference for treatment by Dr. Black at Hahnemann. Dr. Dickter promptly telephoned Hahnemann to advise them of the emergency situation and to secure information regarding the transfer into Dr. Black's care. After the passage of five minutes, Dr. Dickter again called and found

that his contact person was still checking on intensive care unit bed space availability. At approximately 2:20 p.m. Hahnemann called Dr. Dickter and advised him that it would be at least an additional 30 minutes before any information could be provided as to Hahnemann's ability to accept Mr. Pappas as a patient. Dr. Dickter then telephone Dr. Mucci at MCP to ascertain whether the patient could be transferred to that facility. Within ten minutes Dr. Mucci returned the call and expressed that the patient could be accepted. Ultimately, Mr. Pappas was transported to MCP.

This lawsuit was brought as a consequence of the injuries allegedly sustained by Mr. Pappas resulting from delay in treatment while Haverford's staff attempted to make appropriate arrangements for care of the plaintiff's neurologic emergency. Plaintiff alleges that the delay exacerbated his spinalcord compression which resulted in quadriplegia. Haverford filed a third party complaint joining USHC as a third party defendant for their refusal to authorize a transfer of Mr. Pappas to a hospital selected by the physicians at Haverford. Moreover, the third party complaint suggests that USHC is liable over to Haverford for any award which might result from this action. Dr. Asbel, in his answer and new matter, filed a cross claim seeking contribution and/or indemnity from the third party defendants, USHC.

II. PROCEDURAL POSTURE

Third party defendant, USHC, has filed a motion for Summary Judgment alleging that the third party complaint filed by Haverford must be dismissed under the preemption provisions of the Federal Employment Retirement Income Security Act of 1974 (ERISA). *See* 29 U.S.C. § 1001, *et seq.* (1990). Haverford has responded by asserting that this court lacks jurisdiction to either determine whether ERISA preempts state law or the substance of HMO-PA's preemption arguments.

Any intelligent analysis of the issues raised must be predicated on an understanding of the nature of the ERISA provisions and a fundamental understanding of the nature of preemption. As such, we will address those issues first.

III. DISCUSSION

As a threshold matter, the court must determine whether it has jurisdiction to render any decision in regard to the present litigation. Haverford conveniently ignores a number of cases which decided issues involving ERISA claims. Inferentially, the fact that our appellate courts would consider the substance of such matters suggests that no legal impediment exists which divests a state court of jurisdiction over such issues. *See McClellan v. Health Maintenance Organization of Pennsylvania*, 413 Pa.Super. 128, 604 A.2d 1053, *appeal denied*, 532 Pa. 664, 616 A.2d 985 (1992); *DeGenova v. Ansel*, 382 Pa.Super. 213, 555 A.2d 147 (1988).

Haverford has failed to identify any specific provision of ERISA which would divest this court of jurisdiction. Instead, it directs our attention to language in the statue which provides that Federal courts, with certain exceptions, shall have exclusive jurisdiction of civil actions brought by the Secretary of Labor or by a plan's "participant, beneficiary or fiduciary." 29 U.S.C. § 1132(e)(1). Certainly, Haverford's cross-claim is in the nature of a civil action. However, Haverford cannot maintain that its third party action is brought "by the Secretary of Labor or by a Plan's 'participant, beneficiary or fiduciary'." All of these parties (as defined by ERISA) are individuals. No corporate entity such as Haverford may avail itself of the exclusive jurisdiction of the Federal courts under this exclusive jurisdiction of the Federal courts under this specific provision. *See* 29 U.S.C. § 1002(7) (participant defined), 1002(8) (beneficiary defined) & § 1109 (fiduciary defined).

Having determined that this court possesses jurisdiction to decide the preemption issue we may now address the substance of the argument.

Under the Federal Constitution legislation enacted by the Federal government "shall be the supreme Law of the Land ..." U.S. Const. Art. VI, cl.2. Thus, any state law which conflicts with federal law is "without effect." *Maryland v. Louisiana*, 451 U.S. 725, 746, 101 S.Ct. 2114, 2128, 68 L.Ed.2d 576, 595 (1981). Nevertheless, any issue arising under the supremacy clause assumes that the historic police powers of the individual states are not to be superseded by federal legislation unless it is the "clear and manifest purpose of Congress." *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230, 67 S.Ct. 1146, 1152, 91 L.Ed. 1447 (1947).

The intent of Congress may be "explicitly stated in the statute's language or implicitly contained in its structure in purpose." *Jones v. Rath Packing Co.*, 430 U.S, 519, 525, 97 S.Ct. 1305, 1309, 51 L.Ed.2d 604, 614 (1977). In the absence of an express congressional command, state law is preempted to the extent it conflicts with federal law. *See Pacific Gas & Elec. Co. v. Energy Resources Conservation and Development Comm'n.*, 461 U.S. 190, 204, 103 S.Ct. 1713, 1722, 75 L.Ed. 2d 752, 765 (1983). State laws are also rendered ineffectual if a federal law so thoroughly occupies a legislative field as to make it reasonable to infer that Congress left no room for the States to supplement it. *Fidelity Fed. Savings & Loan Assoc'n. v. De La Cuesta*, 458 U.S. 141, 153, 102 S.Ct. 3014, 3022, 73 L.Ed. 2d 664, 675 (1982).

ERISA specifically provides that it "shall supersede any and all state laws insofar as they may now or hereafter related to any employee benefit plan." 29 U.S.C. § 1144(1). The language of the ERISA statute sweeps broadly by superseding all state laws relating to any employee benefit plan. *Morales v. Trans World Airlines, Inc.*, __ U.S.__, 112 S.Ct. 2031, 2037, 119

L.Ed.2d 157, 168 (1992) (breath of scope of ERISA unmistakably relies on "express preemption and construction of the phrase 'relates to'"); *Ingersoll-Rand v. McClendon*, 498 U.S. 133, 138, 111 S.Ct. 478, 482, 112 L.Ed.2d 474, 483 (1990) ("deliberately expansive"); *FMC v. Holliday*, 498 U.S. 52, 58 111 S.Ct. 403, 407, 112 L.Ed.2nd 356, 364 (1990) ("conspicuous for its breadth"); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96, 103 S.Ct. 2890, 2900, 77 L.Ed.2d 490, 501 (1983) (breadth of ERISA's "preemptive reach is apparent from [its] language").

Nevertheless, the preemption clause does not bar all claims. *See* e.g. *Mackey v. Lanier Collection Agency & Serv.*, 486 U.S. 825, 833, 108 S.Ct. 2182, 2187, 100 L.Ed.2d 836, 846 (1988) (state garnishment of ERISA welfare Benefit Plan not preempted; such plans may be subject to suit for state law violations, contractual obligations and torts which are unrelated to the plan's administration).

The crux of the issue then seems to be whether ERISA's preemption provision which provides that any and all state laws are superseded insofar as they "relate to any employee benefit plan" bar Haverford's claims against USHC. *See* 29 U.S.C. § 1144(a). Haverford's third party complaint attempts to establish the liability of USHC by showing that USHC "refused to authorize transfer of [Mr. Pappas] ... to a hospital selected by physicians at Haverford ... as beging able to minister to him." *See* Haverford's third party complaint at paragraph 7. In addition, the third party complaint incorporates by reference the allegations of paragraph 24 of plaintiff's original complaint. That paragraph asserted that Haverford ... was negligent in failing to transfer [Mr. Pappas] ... to another medical facility in a prompt and timely fashion and that Haverford ... inordinately delayed the transfer. *See* plaintiff's complaint at paragraph 24. All of these allegations fall within the rubric of administration of an employee benefit plan. As such, the application of any state law in that regard implicates the ERISA preemption provision.

We must therefore conclude that Haverford's efforts to pursue its third party complaint are barred.

Haverford relies upon inapposite caselaw in support of its contentions. The imposition of a local income tax on employees despite their status as ERISA participants does not implicate a relationship to any employee benefit plain in a substantive sense. See *Firestone Tire and Rubber Co v. Neusser*, 810 F.2d 550 (6th Cir. 1987). Nor does the application of a local tax affect the administration of an employee benefit plan in any substantive sense; thus, mandating the preemption of the action. *See Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47, 107 S.Ct. 1549, 1553, 95 L.Ed.2d 39, 47-48 (1987) (decisional common law cause of action for improper benefit claim processing barred by ERISA because it relates to employee benefit plan).

A number of courts have held that state claims are preempted by ERISA where suit is filed to hold an HMO responsible for injuries resulting from the HMO's own negligent administration of cost containment procedures and funding decisions. *Kuhl v. Lincoln Nat'l. Health Plan*, 999 F.2d 298, 303 (8th Cir. 1993) (ERISA preemptions plaintiff's claim against HMO for denying surgical precertification), *cert. denied* 114 S.Ct. 964 (1994); *Corcoran v. United Health Care, Inc.*, 965 F.2d 1321, 1331 (5th Cir.) (ERISA preempts claim for erroneous medical decision rendered in context of determining plan benefits, *cert denied* 113 S.Ct. 812 (1992); *Elsesser v. Hospital of the Philadelphia College of Osteopathic Medicine*, 802 F.Supp. 1286, 1290-91 (E.D.Pa 1992) (ERISA preempts direct liability claim for failure to fund medical device). In all of these cases, preemption was based upon the fact that the failure to pay a benefit claim or preapprove a procedure possessed an obvious connection or reference to a benefit plan and therefore related to it. Other courts have decided that ERISA does not preempt state law claims against an HMO sued on a theory of vicarious liability generally or ostensible agency specifically. *Elesser, supra,* at 1290 (plaintiff's claim alleging vicarious liability of

HMO for actions of position acting ostensible as HMO's agent not preempted); *Independent HMO v. Smith*, 733 F.Supp. 983, 988 (E.D.Pa. 1990) (same). These cases apply the rationale that the negligence claims have no relationship to a denial of rights under the benefit plan since they do not affect the regulatory scheme devised by Congress in ERISA. Thus, such claims are not sufficiently "related to" ERISA such as to warrant preemption. *See generally Boyd v. Albert Eistein Medical Center*, 377 Pa.Super. 609, 619-20, 547 A.2d 1229, 1234 (1988) (adopting Restatement (Second) of Agency section 267 which outlines the theory of ostensible agency). Given the procedural posture of this case and the fact that Haverford Hospital and not the plaintiff joined USHC to the action, neither of these theories is applicable in this case.

Here, Haverford Hospital seems to suggest that USHC is responsible because its neglect led to a delayed delivery of health care benefits. Yet, there is no dispute but that the delay was occasioned while it was determined which facilities were available to the plaintiff under USHC's programs. We cannot avoid the conclusion that this circumstance relates to the benefit plan. As such, Haverford's motion for Summary Judgment must be denied.

Haverford's final argument concerning ERISA's civil enforcement scheme demonstrates a basic misconception of the ERISA statute. Clearly, certain enumerated and defined parties may seek to invoke ERISA's civil enforcement remedies. 29 U.S.C. § 1132. However, Haverford seems to confuse standing to maintain an action with preemption. The fact that ERISA provides standing to specified categories of individuals which limits redress does not translate to a waiver of preemption. In any event, as observed previously, Haverford, as a corporate entity, possesses no standing to maintain a civil action under ERISA.

For the foregoing reasons, USHC's motion for Summary Judgment was granted.

BY THE COURT

/s/ Charles C. Keeler
CHARLES C. KEELER, J.